Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 0528 AM trsonia, Dorse 09 10 4a. Facility Name (If not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🕽 F Months Days Hours Min 195 216-68-2490 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □Xio Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Crest Haven Drive 20903 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Debt Collector</u> National Financial Gp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aubrey Dorsey Dorothy W. Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Dorsey -Brother 17 East Darby Court, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Ardent Crematory 11/3/09 5 □ Other (Specify) Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 month Presumed Pulmonary Embolism disease or condition resulting in death) Due to (or as a consequence of) Cardiac Arrest - asystole 1 month Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ CUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner** Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be 2 MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantina must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit attending physician for use as the buria signed by the a d be detached fo

Physician/Medical Exami \$ Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid obesity

Chronic leg infection, lymphedemia

1 ☐ Yes 2 🛣 No 27. Manner of Death Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Day, Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Medical

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier CMaherhuser

D0068681

29d. Date signed (Month, Day, Year) 1/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maheshwary - 1500 Forest Glen Rd, Silver Spring, MD 20910

31. Date filed (Month, Day, Year) NOV 03 2009

State

Christopher Averander Douglandry Funda International Control of Death Projection Control of Death	09-08676		Please Type or Print in Black Indelible Ink. Ensure All Copi						
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296. Signature and title of certifier O.C.M.E. November 8, 2009 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the Hospi iin 24 hou the Funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as	nd due to the cause(s) ar	nd manner as stated.				
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Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			in with o.c.m.e.	Nov	vember 8, 2009				
Registrar			31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 6, 1359 2009 Faye L. Denison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett 0akland Garrett County Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 08/12/1921 Ohio Director 184-24-2044 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 🙀 No Director MD Garrett 0akland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21550 1819 Lakeshore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Experiment 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. þ 3 Widowed 4 □ Divorced Year or Dates: White WWIT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara ဂ Ear1 Garber (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crescent, PA 15046 1225 Crescent Blvd. Ext., John Denison, Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 11/08/2009 4 Donation 5 Other (Specify) Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner artes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed and burial-trar attending physician law requires that the death certificate be Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) ☐Yes signed by the a d be detached f 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Wes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records, spital or Attendi nours after death. neral Director: A Hospital To the Hospital within 24 hours and To the Funeral L completely

Medical 29c. License number and title of certifier 29b. Signatur DZ6650 of death (Item 23a) (Type, Print) 32. Registrar's Signature State

determined

4 Homicide

(Check only one)

29a, Certifier

Registrar

🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2/1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Floyd Wilbur Devilbiss 29, 4:11 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 3212 Uniontown Road 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. 1 M 2 □ F Months Days Hours 219-20-2968 85 Aug 20, 1924 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c City Town or Location 10a. State 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, titem 22.7 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it. Wickel Even. Westminster 1 ☐ Yes 2 No Carroll Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 3212 Uniontown Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 M Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Owner/Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche M. Hahn Wilbur Henry Devilbiss Pages 1 and 2 should 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau
once. 3212 Uniontown Road, Westminster, MD 21158 Anna Marie Devilbiss, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Lutheran 11/02/2009 Uniontown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 83a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY Physician YEARS /Medical Due to (or as a consequence of): ADULT DIABETES MELLITUS Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last True to for as a consequence of Examiner The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No Month Day Pregnant at time of death 5 Other (specify) signed by the a 1 □Yes Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been sig 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONE KINGS DRIVE TANGYTOWN, MD 21787

State Registrar

DHMH 17 Rev 1/2001

WILLIAM R.

31. Date filed (Month, Day, Year)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

37005 State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death

Physician/ Medica Examine
Funeral

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innarial director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	For State Registrar	Cer	tificate of De			g. No.		3 1003			
n/	1. Decedent's Name (First, Middle, Last) Rachela	Fershir	ng		2. Date of Death Month November		Year	3. Time of Death 7:35 AM			
er	4a. Facility Name (if not institution, give street and number) The Hebrew Home of Greater	Washington	4b. City, Town, or Loc Rockville	Location of Death 4c. County of Death							
	5. Social Security Number 262-81-9085 6. Sex 1 ☐ M 2 🔏 7. Ag	e (In yrs. last birthday) 90 Yrs.	If Under 1 Year If	Under 24 Hrs. ours Min.	8. Date of Birth 2 / 10 / 19 1		9. Birtho	lace (State or Foreign			
ector	Usual Residence of Decedent	10c. City, Town or Loc Silver Sp					11	0d. Inside City Limits			
eral Dir	10e. Street and Number 11008 Oakwood Street	Og. Citizen of W Unite	hat Coun ed St	try? cates							
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	. No	Was Decedent of Hispa f Yes, specify Cuban, N I ☐ Yes 2 🛣 No S	lexican, Puerto	cify Yes or No- Rican, etc.)		- America k, White, e	an Indian, atc. White			
Complet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 9)	siness Inc	dustry								
To Be	17. Father's Name (First, Middle, Last) Wolfe Stockhammer	1									
	Wolfe Stockhammer Leah Sarah Rosenbaum 19a. Informant's Name/Relationship (Type, Print) Leah Yifrah - Daughter Leah Sarah Rosenbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11008 Oakwood Street Silver Spring MD 20901										
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo- cemetery, crem Garden of	risition (Name of natory or other place) Rem. Mem.	į		Clarksbu	•				
	21. Signature of Funeral Service Licensee MO 1		Name and Address of Ward 1091 Roo		l Direct Pike Roc	ion In kville	EMD 2	20852			
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ente. Underlying Cause (Disease or iirijury that initiated events Due to (or as Hypert b.) Due to (or as Diabet cause (Disease or iirijury that initiated events)	e. Artery I a consequence of): Cension a consequence of):		uch as cardiac o	r respiratory arres			Approximate Interval Between Onset and Death			
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 reports? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delive	ery Day Year			
d by Pr	Part II. Other significant conditions contributing to death to Peripheral Vascular Dise		inderlying cause given	n Part I.				e cause of death?			
Complete	Dementia		<u> </u>		24a. Was an autopsy perform	/ P	/ere autoprior to coreath?	osy findings available mpletion of cause of 2X No			
To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ☐ ER/Outpatier	Tail	of Death <i>(Check</i> X Nursing Ho	only one) me 5 🗆 Resider	nce 6 🗆 Othe	r (Specify))			
icate:	27. Manner of Death 1	ury 28b. Time of injury	28c. Injury at work?			ribe how injury occurred					
Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inj building, et	r or Rural	Route Number,								
Medic	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of 6 only one) 3 Certifying Nurse Practioner: To the	examination and/or invest	tigation, in my opinion, o	leath occurred at	the time, date and	place, and due	to the cau	use(s) and manner stated.			
	29b. Signature and title of certifier	am	29c. License nu D5788		29	d. Date signed	(Month, L	Day, Year)			
	30. Name and address of person who completed cause of a Damian Doyle 6121 Montrose	Road Rock	ville MD 2	0852							
te ar	31. Date file (Morth, Day, Year) 32. Registr	ar's Signature									

Sta

Examine

Funeral Director

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland be permit of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If tiem 27 is marked other than "natural", or items 23a or 28a-5 show any injury or other traumatic event. If Mental Hygiene is notified at
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit

once.

	1 - For Amend Item 25 p	per me, g897,1	d / Depa 1 / 18/09 <i>Cer</i>	irtment of He gdhb <i>tificate of L</i>	eaith and i Death	vientai Hygi Re	ien 2009	37006
an	1. Decedent's Name (First, Middle, Last)	Paul1-				2. Date of Death Month	Day Year	3. Time of Death
er	Justina Mae 4a. Facility Name (If not institution, give s		Т	4b. City, Town, or I	Location of Death	11	4c. County of Dear	th
E	WMHS-MEMALIA	L HOSPITA	1	1 11 m	BEPL	AND	ALLE	EGANY
	5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	234-38-/989	82	Yrs.			June 23		adsville, WV
	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
ō	WV Minera	1	TZ					1 X Yes 2 ☐ No
rec	10e. Street and Number	1	Key	10f. Zip Code		10	0g. Citizen of What Co	ountry?
a D	315 Keys Street			267	26		USA	
Funeral Director		Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	14. Race - Ame Black, White	
	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1		☐Yes 2MNo	Specify:	rusuri, story	Specify:	White
Completed by	15. Decedent's Educi	ation	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Business	
ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D	kind of work done du OO NOT use retired)	uring most of work	ring		
Con	9		Но	memaker			Own H	ome
Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Surname)	
၉	Elijah S. Parish		Τ			. Martin		
	19a. Informant's Name/Relationship (Type William J. Faulk/	•		`			City or Town, State,	Zip Code)
-	20a. Method of Disposition	20b. Pi	lace of Dispos	S. Main S	1	<u>Keyser, l</u> Date 2	WV 26/26 20c. Location - City or	Town, State
	1 MBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	emorial G	NOV	. 12 2009	Vorteor	7.777
	21. Signature of Funeral Service License			. Name and Address			Keyser, ral Home	W V
	1 Brian F	Sulls		85 S. Mai				726
	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.					est,	Approximate Interval Between
	Immediate Cause (Final disease or condition	Sulo	dur	A LC	mo to	ma		Onset and Death
	resulting in death)	Due to (or as a consequ	uence of):					
P.	Sequentially list conditions, b.							
Examiner	Cause, Enter Underlying Cause (Disease or injury	Due to (or as a consequ				1	1 //	
Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):		-	//	// //	
edical	d.					$-\mathcal{H}_{A}$	// //	11111
Med	IF FEMALE:					1 3	TIA W	1411107
ian/	23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy		03	23. Pate of de Month	livery Day Year
Be Completed by Physician/M	1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5∐	Other (specify)				
Y Ph	Part II. Other significant conditions cont	ributing to death but not resu	ılting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
d b						1 □ Ye	s 2000 3 P	robably 4 🗌 Unknown
olete						24a. Was ar		utopsy findings available
mo						autopsy perform	ned? death?	completion of cause of
3e C	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only one		
	1∭ Yes 2————————————————————————————————————	ospital: 1 Inpatient 2 I		t 3 ☐ DOA Other	r: 4 🗆 Nursing Ho	ome 5 Reside	nce 6 Other (Spe	ecify)
ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	'	28d. Describe ho		
icat	2 Accident investigation 3 Suicide 6 Could not be	1//03/3005			es 2 ANO		M/ reet and Number or R	ural Poute Number
ertif	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	/)	ot, lactory, office		City or Town	State) STRF	TKEYSER
alc		ician: To the best of my know			e, date and place	, and due to the ca	ause(s) and manner a	s stated. WVA
Medical Certification: To	(Check only 2 Medical Examin	er: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my op	inion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
Σ	29b. Signature and title of certifier	11.		29c. License	number	25	9d. Date signed (Moni	th, Day, Year)
	· wan	Watt	n) 05	3158		11/691	5007
		Rowalls	rie	Print)	mbel	100	cl m	1500 g
te ar	31. Date filed (Month, Day, Year) NOV 1 8 2009	32. Registrar's Signar	pure Carlos					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31, 2009 **Physician** 12:30 A M Barbara S. Goldsteen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 9, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖺 F 1943 Illinois 326-34-8402 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evantment must be notified at 1 Yes 2 No Director Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 1107 Regal Oak Drive 20852 U.S.A. Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □ Yes 2 □No Specify. \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Manager Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Skolnick Epstein Ann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1107 Regal Oak Drive Rockville, Maryland 20852 Mark B. Goldsteen/Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Judean Mem. Gardens 11/2/2009 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Laward Sage1 22. Name and Address of Facilityward Sagel Funeral Direction. INC M00910 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each june. cancer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year signed by the aid be detached for 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been strompletely filled in by the funeral director, page 2 should it. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2X No 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/3/109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Salehi Pirouz, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 3. Registrar's Signature State NOV 03 Registrar

DHMH 17 Rev 1/2001

E

Goldsteen, Barbara

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bobby Giles 2009 October 6:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F Days Hours Country) Texas 79 Yrs Director 461-46-5552 August Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 x Yes 2 No Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20912 8116 Flower Avenue United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 Widowed 4 X Divorced White Year or DatesKorean 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Rancher Ranch Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဂ Martin Giles Homer Pearl 1 and 2 should to the street and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8116 Flower Avenue; Takoma Park, MD 20912 Langston / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory: 11/03/2009 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signatura of Funeral Service .040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Case (Final Physician/ disease or condition ronic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a sunsequence of, attending physician and for use as the burial-transit certificate be executed Due to for as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Yes 2 No ed by the detached g Unknown P.O. been signed the should be determined by the should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s performe this certificate Yes 2 No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 68049 10/26 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA CARROLL AVE, TAKOMA PARK, 7600 MD 20912

State Registrar 31. Date filed (Me

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_1	For State Registrar				rtment of He tificate of D		R	eg. No.2	19 3	7009	
Physiciai /Medica	n il -	1. Decedent's Name (First, Midd MARGUERITE E	LLEN GUERN					2. Date of Deat Month NOVEMBER	Day 20	Year 2:5	ne of Death 54 P M	
Examine		4a. Facility Name (If not institution, give street and number) 7484 TOUR DRIVE				4b. City, Town, or Location of Death EASTON If Under 1 Year If Under 24 Hrs.			4c. County of Death TALBOT 3. Date of Birth 9. Birthplace (State or For			
uneral rector		5. Social Security Number 081-50-2539 Usual Residence of Decedent	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	(Month, Day,	^{Year)} 2,1954	Country) NEW YORK	ale or Poreign	
iffed at	.	10a. State 10b. Count	LBO T		r, Town or Loc	ation				1 29	de City Limits (Ýes 2 No	
3a or 28	5	10e. Street and Number 7484 TOUR DRI	VE			10f. Zip Code 21601			0g. Citizen of W UNITED			
0,5	by ru	11. Marital Status 1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Fo 1 □ Yes If Yes, Gi	2 No ve	If	/as Decedent of His Yes, specify Cuban □Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American India , White, etc. WHITE	ın,	
er than "natu t, the Medical	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occupat ind of work done du O NOT use retired) KEEPING	ring most of work	king	OWN BU	SINESS		
rked oth	lo Be	 Father's Name (First, Middle H. W. GUERNS 						ne (First, Middle, I NE BAUM	faiden Surname	s)		
27 is ma r trauma		19a. Informant's Name/Relation DAVID GUERNSE				Address (Street ar		ral Route Number E PLAINS				
ant: If item ary or othe	-	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (State CHÉ	SAPKAK CENTER	ition (Name of aron or atterniace	ON			City or Town, Sta		
Importa any Inju		21. Signature of Funeral Service		ERSO	22.	FELLOWS,						
	ਲ । ਕ	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
y the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 V No 9 □ Unknown	1 Live	atcome of pregna birth 2 ☐ Fetal gnant at time of d nown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day	Year	
n signed by	2	Part II. Other significant condi	tions contributing to d	eath but not resu	ulting in the un	derlying cause giver	n in Part I.	23e. Did tobacco use contribute to the cause of dea				
ificate has bee	Completed	25. Was case referred to medic	val .				26. Place of Dea	24a. Was an autopsy findings avail prior to completion of cause death? 1 □ Yes 2 ▷ No 1 □ Yes 2 □ No			n of cause o	
this of dire	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves	Hospital: 1 28a. Date (More stigation		ER/Outpatient 28b. Time of Injury	t 3 DOA Other	1: 4 ☐ Nursing H	ome 5 Resid	sidence 6 Other (Specify) e how injury occurred			
al Directo	Certification:	3 Suicide 6 Coulide determined	rminod 286. Place	e of Injury - At ho ling, etc. (Specif	me, farm, stre	street, factory, office 28f. Location (Street and Number or Run City or Town, State)				er or Rural Route	Number,	
he Funer	Medical		al Examiner: On the					urred at the time, o	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)			
To com	Σ	29b. Signature and title of certif	ier	tol		29c. License	number 17232		9d. Date signed	(Month, Day, Y	ear)	
		1	LL DIN	non			11406		1)3 20		

*				partment of F ertificate of			g. No. 2 N	09 370				
1. Decedent's Nan	ie (First, Middle,	Last)				Date of Death Month		3. Time of Dea				
Wi1	liam Da	aniel Grim	es	०१ २।:25								
		give street and number)			r Location of Death		4c. County of	of Death				
		al Hospital			timore Cit			0. 5: 11. 1 (01.1 5:				
5. Social Security		6. Sex 7. Ag 1	e (In yrs. last birthda 59 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 15	Year) 950	9. Birthplace (State or Fo				
217-58-0		Λ	39			Teb. 15	, 1950	TID				
10a. State	10b. County		10c. City, Town or	Location				10d. Inside City L				
MD	Howa	ard	Day	ton				1 □ Yes 2				
10e. Street and Nu	mber			10f. Zip Code		10	g. Citizen of W	hat Country?				
4720 Li	nthicum	Road		210	36			USA				
11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.				
	ried 2 Marrie		No	1 □Yes 2√□No	Specify:	indan, etc.,	Specify:					
3 🗆 Widowed	11	Year or Dates:		Λ			_	WIITCE				
(Spe	15. Decedent's cify only highest	s Education grade completed)	ı (Gi	cedent's Usual Occup ve kind of work done	during most of worki		6b. Kind of Bus	siness/Industry				
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		rimes, Sr.			_	rine Gen						
			10h 14	illing Address (Street								
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherine G. Grimes (Mother) 4720 Linthicum Road, Dayton, MD 21036												
Mrs. Catherine G. Grimes (Mother) 4720 Linthicum Road, Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location - City or Town, State												
1 X ☐ Burial 2	Cremation 3	3 Removal from State				/2000	011	-11- MD				
	5 Other (Sp.		-1	m Chapel (ille, MD				
21. Signature of Funeral Service Licensee 12. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784												
23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between shock, or heart failure. List only one cause on each line.												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Ye ar 1040 AM na 2009 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Northwest 6 anda a -0 Sex If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05/22/1954 Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) Months 1 □ M 2 □ F Days Hours Min 55yrs Director 213-70-5409 CZECHŐSLOVAKIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It o Mystical Examiner must be notified at once. MD BALTIMORE 1 ☐ Yes 2 No Director RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 SHERATON RD. 21133 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 4YRS College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE DIRECTOR INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LADISLAV SOUCEK HANA VALASKOVA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALOJZ GARDOS (HUSBAND) 32 SHERATON RD. RANDALLSTOWN, MD. 21133. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2. Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 10/28/2009 SYKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fire) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performe 1 ☐ Yes 2 🗷 No 1 🗀 Yes 2 □ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural nours after death. 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi one) 29b. Signat title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 401 020 6041 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Hopkins Gloria Oct Sa /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Ro**c**kville Montgomery f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □XF **Director** 218**-**56-2743 9/29/28 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shortranmatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19851 Chesley Knolls Drive 20879 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Hame permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Item 27 is marked othe any Injury or other the contraction. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Love Bertha Smallwood ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19851 Chesley Knolls Drive, Gaithersburg, MD 20879 Gloria Stewart - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State of Heaven Ga\te 11/2/09 Silver Spring, MD 4 ☐ Doganon 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the dis + se, or complication shock, or heart failure. List only or ons that caused the death on ot enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) IMARCHION **Physician** Aute Myrearhal minutes /Medical Due to (or as a consequence of): minutes **Examiner** Ceveropulmoun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, <u>Р</u> О Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed

To the Hospital or Attency within 24 hours after death To the Funeral Director: filled in by

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner a	s stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due	
one)	and manner stated.	, ,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Rue KVILLE VIPUL CENTEL KELLA MECICAL MO

29c. License number

2068207

29d. Date signed (Month, Day, Year)

State Registrar

Amend 10a-c& 10e-f, per FD G897 11/18/09 TI. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 29 2009 10:45 a Mary L. Hoesl /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Transitions Health Care Westminster 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 08/01/1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 301-03-1742 89 Ohio Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County Palm Beach 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Examinar must be notified at 1 ☐ Yes 2 No Director Md FL Carroll Westminster Boynton Beach 10g. Citizen of What Country? 10e. Street and Number 709 Sunny South Ave. 10f. Zip Code 33436 50 East Nicodemus Rd. $\frac{21157}{}$ USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3X Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2Yrs Elementary/Secondary (0-12) Secretary Real Estate Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William T. Walsh Mae Birkenmaier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy A. Thomas(Daughter) 50 East Nicodemus Rd. Westminster, Md. 21157. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 1/0/3//2009 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleyal Service Lansee 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. P.O. Box 195 Sykesville, Md. 21784 Approximate Interval Between Obset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examine xexts Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) burialphysician the burial O. Box 68760. Physician/Medical the attending posterior that the attending posterior that the posterior than the posterior that the posterio IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a 9 Hlnknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Saver DK Satk 30 NETHODIER M NO 31. Date filed (Month, Day, 32. Registrar's Signature Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#7perFH, 11/3/09, EMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 07:22A M Retha Hall 2009 /Medical 27 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery
Birthplace (State or Foreign Holy Cross Hospital

5. Social Security Number 6. Sex Silver Spring 8. Date of Birth (Month, Day, Yea 01/01/20 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔽 F Months 239-24-4588 Yrs Cárolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Expriner is set to be reference. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director DC. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20011 USA 5702 Georgia Ave. NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Postal Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Major Atkinson Vera Benton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn B. Taylor/Niece 9113 Linhurst Dr. Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 11/14/09 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee (1) 7 3831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Week Pulmonary Hemorrhage resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Week Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed Cellulitis 1 Week been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed 1 ☐Yes 2 ☐ No 1 □ Yes 2 🖳 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Makeshwan M 10068681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charu Maheshwaru -1500 Forest 20910 Silver Spring.MD Glen Rd. 31. Date filed (Month, Day, Year) egistrar's Signature State NOV 03 2009 Registrar

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	/Medid		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	2.000	4c. County of Death		11.13 1
	Examin	ICI	800 Marley Rd.	,		Elkton			Cecil		
	Funeral	Г	Social Security Number 6.	Sex 7. Age ('In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birthp	place (State or Foreign
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	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	e - Americ	can Indian,
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yland	Ald be Menta rked tic ev	To B	Paul J. Hensler	•			Ona Ve	rnon			
Mar	and I and I is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	and Number or Rui	ral Route Numb	er, City or Town,	State, Zip	Code)
e Č	and		Carla M. Hensle	er/Daughter			Dr., Pit			5147	
o e	ges 1 t of H If iter or oth		20a. Method of Disposition 1 X Burial 2 X Cremation 3 D	Removal from State	•	matory or other plac	ce) 11-06	Date 5-2009	20c. Location -	-	
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0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exyminational to main any once.		21. Signature of Funeral Service Life	nsee	2		ess of Facility rd and Ge ain St.,		MD 219	921	
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5	alor, safter safter al Dire	Certification: To	4 ☐ Homicide determined	building, etc. ((Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. to the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical (nysician: To the best of i miner: On the basis of e and manner state	xamination and/or i						
	To the Complex	M	29b. Signature and title of certifier	Hostand	2-	29c. Licens	se number	53	29d. Date signe	d (Month,	Day, Year)
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,	THVA		Martha A. Hosfor			•	Suite 104	, Elkto	n, MD	21921	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 11 Day 20<u>09</u> Physician/ Krile cichard 5:50 am^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Flintstone 23019 Gilpin Road 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Hours (Month, Day, Y 190-28-5171 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Allegany MD Flintstone 1 Yes 2 X No 10e. Street and Number 10g, Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral Gilpin Road 23019 153 Inited Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) **US Government** E6 Petty Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Margaret Anna Mahler Kriley Elmer Joseph Krilev other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 23019 Gilpin Road Flintstone 19a. Informant's Name/Relationship (Type, Print) 23019 Gilpin Road MD 21530 . Page 1 and 2 shament of Health a tant: If item 27 is Reva Krilev wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
Delaware Veterans Mem.Cem. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/17/2009 DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

Immediate Cause (inal disease or con thin or resulting in de to)

a. Metastatic non-small cell lung Carcinoma

Due to (or as a consequence of): Approximate Interval Between Onset and Death Ph sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Tuneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMA! F 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death Yes 2 No is certificate has been signed by the a director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Coronary Artery Disease 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? Renal Disease 1 🗌 Yes 2 🗌 No Chronic 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D45563 2009 November 11,

State Registrar 31. Date filed (Month, Day, Year)

324 East Antietam Street Suite 203, Hagers Town, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# I per PHYS# I oper FH, G898, 12 (4709, WS)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Bernard Korenblit
Benard Korenblit Р 2009 29 2:36 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery General Hospital
5. Social Security Number | 6. Sex | 7. Aq 01ney Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Yrs. 92 New Jersey 10/03/1917 467-38-9055 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 □ No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15100 Interlachen Dr. #810 20906 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give WWII Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Administrator John Hopkins APL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milt <u>Jacob Korenblit</u> Anna Melt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) #810 Dr. Silver Spring MD. 20906 15100 Interlachen <u>Sonya Korenblit / Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Grdns 11/01/2009 Olney, Maryland 21. Signature of Fun. 1 Service Licensee Edward Sage1 22. Name and Address of FacilityEdward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Lymphocytic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 12 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation М 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

that the death certificate be executed sician and burial-trans inding physician a Division of Vital Records, P.O. Box 68760 nse atten for us signed by the a page 2 s nas the Hospital or Attending Physician; The certificate this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Expropries roust be restilled at

Baltimore, Maryland 21215-0036

1 and 2 should be fill Health and Mental H tem 27 is marked ott

Health a tem 27 is

permit. Pages 1 and : Department of Health Important; If Item 27 any Injury or other tra once.

Physician

/Medical Examiner Director

Funeral

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

29b. Signature and title of certifier

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State Registrar

Muntponera,
32. Registrar's Signature Cererel Hopital Debomh Steir, D.O. 31. Date filed (Month, Day, Year) NOV 03 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

40065661

29d. Date signed (Month, Day, Year)

They MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FD 9900 2/2/10 TT Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1507 M October 30 Ralph J. Klein /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sandy Montgonery Brooke Grove Rehabilitation and Nursing Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. Tast birthday) 3. Date of Birth (Month, Pay, Year) June 6, 1921 Birthplace (State or Foreign **Funeral** Days 1⊠M 2□ F Hours 292-18-4061 88 Óhio **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 □ No Directo MD Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 18131 Slade School Road 20860 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1⊠Yes 2∏No If Yes, Give Year or Dates: Army 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baker Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius Klein Regina Feitel ည permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 is m any Injury or other traum once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Pearl - sister 26101 Village Lane Beachwood, Ohio 44122 20c. Location - City or Town, State Solon, Ohio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Durial 2 ☐ Cremation 3 Removal from State Mt. Olive Cemetery Nov.3, 2009 Cuyahoga County 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licenses MO1477 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** senile dementia YEars disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown complete neart block 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy 2**V** No 1 □ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only To the Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42046 3 attending physician Name and address of person who completed cause of death (Item 23a) (Type, Print) Slade School Road Sandy Spring, Maryland 20860 Grace Brooks Huf 18100

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland 1 - State Amend Item 2 per dr., g897, Registrar	/ Depa 11/18 <i>Cer</i>	ortment of H 3/09dhb Tificate of L	lealth and N Death	/lental Hyg R	iene _{eg. No.} 2 (009	37019
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day	2009 Year	3. Time of Death
	/Medic		Harriet Margaret	L	ong		November	T .	109	10:35 ^A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Homewood at Williamsport		-	Location of Death	4c. County of Death Washington			aton
*C	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	Director		220-30-9734	Yrs.	Months Days	Hours Min.	eptembe:	15,1	909Ma:	ryland
	pur 🔏		Usual Residence of Decedent 10a, State 10b, County 10c, City, T	own or Loc	cation					0d. Inside City Limits
	Aaryle f sho	ō			amsport					1 □ Yes 2 No
	the P	irect	10e. Street and Number	<u> </u>	10f. Zip Code		1	0g. Citizen o	f What Cour	ntry?
	h with	Funeral Director	16505 Virginia Avenue		21795	5		U.S.	Α.	
	ems a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14. Ra	ace - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Michael Examiner mast be redified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		I∐Yes 2∏XNo	Specify:	, , , , , , ,	Spec		• •
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<u>lan</u>	Aenta Aenta rked tic ev	To B	Harry Gross Doub Si	r.		Margar	ret D	elva	В	owers
ary	and N		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Rur	ral Route Number	City or Tow	n, State, Zip	Code)
≥, <	and and m 27		M. Kenneth Long Son	1871	5 Fairfie	eld Road,	Hagerst	own, N	Maryla	nd 21742
20	iges 1 nt of 1- if ite or ot		TABBunal 2 Li Cremation 3 Li Removal from State		sition (Name of natory or other place			20c. Location		
altimore,	artmer artmer ortant Injury				Cemetery					Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licensee R. host Brady	7	Name and Address ndrew K. O East Ar	ICTE COIII 2	treet, r	agers	Inc.	Md. 21740
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to a property of the cause in the	ce of):	Den	ENTA				Approximate Interval Between Onset and Death
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequent) d.	ce of):						
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5	s certi irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outnotion	Othe	26. Place of Deat			W (0	3,000
on of	iding Phys th. After this funeral dir	tion: To		b. Time of Injury	28c. Injury Work	at	ome 5 ☐ Reside 28d. Describe ho			y)
DIVISI	l or Attend after death Director: /	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	, farm, stre		-	28f. Location (Si City or Town		mber or Rum	al Route Number,
_	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination manner stated.	dge, death	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and ate and place	manner as s e, and due to	stated. the cause(s)
	To th Within To th	Me	29b. Signature for the di pertifer	Χ.	29c. License	number	2	9d. Date sign	hed (Month,	Day, Year)
			May Marian	XALC	71	1106)	111	7/0	07
31	4-2		30. Name and address of parson who completed cause of death (Item 23	134	24 Pat	he STE	161 /	AGGA	Ham	Jubury
	Sta Registra		31. Date-filed (Month, Day, Year) 32. R distrar's Signature NOV 1 0 2009	1 1	all	(-	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM u /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner more VA BALLIMORE enter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F 88 176-16-0191 Director 10/23/1921 PA Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 □ No Director PA Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39 Williamson Ave. 17225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates 1943-1945 Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important; If item 27 is marked other any Injury or other traumatic event, the Mean sonce. Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Lauffer Emma Roberts 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian G. Lauffer-Wife 39 Williamson Ave. Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place)
Indiantown Gap National Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/2009 Annville, PA 22. Name and Address of FacilityZimmerman & Son Funeral Home Inc 45 S. Carlisle St. Greencastle, PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DAVS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CENTIFICATION APPROVED BY MEDICAL To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been sig page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending LON DRIVE WA 2 Accident investigation 10-27-2009 UNKROLONM 1 ☐ Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Alrial Route Number, City or Town, State) 39 WHA AMSON AVE GREEN CASTLE PA determined 4 Homicide Resident 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only

31. Date filed (Month, Day

29b. Signature and title of certifier

C.M WM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

LO NORTH GREENEST BALTIMORE, MD 21201

29d. Date signed (Month, Day, Year)

316

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #Hares Playve 6898 12401 #69 or Health and Mental Hydiene

			For State Registrar	end #Stafes	ifl ey yl G8	-	1⊧⊮69 nt ŏf1 <i>rtificate of</i>			giene Reg. N2009	37021
			1. Decedent's Name (First, Middle Elorna	e, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medi		SHIRLEY HELTANG	R LOMAX					October	28, 2009 ear	17:29 M
	Examir	ner	4a. Facility Name (If not institution					r Location of Death	1	4c. County of Dear	th
A.	Emand		Washington Adventus Social Security Number	entist Hos	spital 7. Age (In yrs.)	last hirthday)	Takoma If Under 1 Year		8. Date of Birt	MONTGOM	ERY thplace (State or Foreign
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	Maryla f sho	o		a		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a	Director	MD Princ	e Georges		В	eltsville 10f. Zip Code	9		10g. Citizen of What Co	21
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	r dear	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.\	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	- 14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any holury or other traumatic event, the Modeal Exantive 1: ust be neithed at once.	by Fi	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced		2 <u>I</u> ∏ No ve		□Yes 2X No	Specify:	7	Specify: Bl	
9	2 houral	ted	15. Deceden	t's Education	ates.	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business/	
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121	led wi lygier her th		12th			Hom	emaker			Home	
anc	d be fi	Be C	17. Father's Name (First, Middle, William Hall	Last)						Maiden Surname)	
ary	shoute nd Me mark	ြ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	a Address (Street		Gaithe	C er, City or Town, State, 2	Zin Code)
ž	and 2 palith a n 27 is er tra		William Edward	Lomax (H	usband)	1		L Court,			
Baltimore, Maryland 21215-0036	of He if item or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 □ Bemayal from t	20b. P	lace of Dispos	sition (Name of natory or other place	^(e) 11/6	Date /00	20c. Location - City or	Town, State
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Bal	Departing on the popular on the popu		21. ign ture of Funeral Service	Licensee	4					JNERAL HOME	
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	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	bAc;	idosis						
_	rted nsit	nine	Contract To Approx 1775 Institute to		or as a consequ					- 21	
<i>)</i>	execu in and ial-tra	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>H</u> V Due to (oertens or as a consequ	ence of):					
58760,	ficate be executed physician and s the burial-transit	edical		d. Hy	M. Hypoglycemia						
ox O	law requires that the death certific as been signed by the attending p 2 should be detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnar	ncy				23d. Date of del	ivon
P.O. Box	death	Physician/M	in the past 12 months? 1 □Yes 2∑No	4 ☐ Pregr	oirth 2□ Fetal ant at time of de		Ectopic pregnance Other (specify)	4		Month	Day Year
<u>Ч</u>	uires that the de 1 signed by the a 1d be detached f	Phys	9 Unknown	9 Ll Unkno					0		
ds,	signe signe	ρ	Part II. Other significant condition Respirator							obacco use contribute to res 2 □ No 3 □ Pr	
000	w requir s been s should	letec		-	•	HC Rei	lat fallu	пе	11		
Division of Vital Records,	The law te has age 2 a	Completed	Anemia; S						24a. Was a autop perfor	sy prior to o death?	topsy findings available completion of cause of
ta	siclan: The certificate h rector, page	BeC	Encephalor 25. Was case referred to medical	pathy; Ser	osis			26. Place of Deat			2 □ No
<u>></u>	Physic this ce al direc		examiner? 1 ☐ Yes 久 ☐ No	Hospital:	npatient 2 🗌 E	ER/Outpatient	3 □ DOA Othe			lence 6 Other (Spec	cify)
Ĕ.	ing (ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		of Injury h, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurred	
isic	al or Attendi s after death. I Director: A d in by the fu	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot bo	of Injury - At hor	ne farm stre	_	Yes 2 □ No	28f Location (C	Street and Number or Ru	uml Pauta Alumbar
2	al or / s after il Dire ed in b	Certification: To	4 ☐ Homicide determi	ned buildir	ng, etc. (Specify)	et, factory, office		City or Tow	n, State)	rai Houte Number,
	To the Hospital of Within 24 hours at To the Funeral D completely filled in	Medical (29a. Certifier 1 Certifying (Check only one) 1 Medical E	g Physician: To the Examiner: On the ba	asis of examinati	vledge, death ion and/or inv	occurred at the tine	le, date and place, pinion, death occur	and due to the or	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Vithin To the Somple	Me	29b. Signature and title of certifier	and main	er stated.		29c. License	number	2	29d. Date signed (Monti	n, Day, Year)
5	5) (VL				D05	7649		10/28/09	
			30. Name and address of person was Bryan Steinber					Sto 207	Cilvar	Spring, M	20002
	Stat		31. Date filed (Month, Day, Year)	320 Da	nietrar'e Signati	IFO.		3 CE 30 /	, erroer	. obrind, m	
	Registra	ar	NOV 0 3 2	1009 Cent	un A.	par	and .				

			For State	State	of Maryla		artment of H			-	_	000	0.7	
			1 - State Registrar	-41		Ce	rtificate of	Deatr	7	2. Date of De	Reg. No.	009	31	022
	Physicia	an	Decedent's Name (First, Middle, La	,	1 1.					Month	Day	Year	3. Time o	
	/Medic		Gloria Jane 4a. Facility Name (If not institution, given		ndenbau	.m.	4b. City, Town, o	r Longtion		October		2009 ounty of Deatl	7:20	РМ
	Examin	er				4.04								
	Funaval		Warm Heart Assis 5. Social Security Number 6.8			. last birthday)	Germa If Under 1 Year		er 24 Hrs.	8. Date of Birn (Month, Da		ontgon 9. Birtl	place (State	or Foreign
	Funeral Director			1 □ M 2 🔼 F		80 Yrs.	Months Days	Hours	Min.	(Month, Da March l	y, Year) 9 • 19	Co	^{intry)} nsylva	•
-			Usual Residence of Decedent											
	how	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside (,
	a-f s	cto	Maryland Montgo	mery	G	ermant	own						1 ∐Ye:	s 2 🛚 No
	or 28	Director	10e. Street and Number				10f. Zip Code		-		10g. Citizer	n of What Co	intry?	
	23a	ra	11845 Summer Oak	Drive			20874					ted St		
	tems	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic O an, Mexica	rigin? (Spe an, Puerto I	ecify Yes or No Rican, etc.)	14.	Race - Amer Black, White		
2	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, G	2⊠No ive		1 □Yes 2 🖾 No	Specify	y:		Sp	pe <i>cify</i> :		
213-0030	hour	pa		Year or I	Jates:	16a Dece	dent's Usual Occur	nation			16h Kind	oe <i>cify:</i> Whi of Business/I	te	
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<u> </u>	with iene.	m o	Elementary/Secondary (0-12)	College ((1-4or 5+)		nemaker	,			Own	Home		
2	filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)		,		18. Moth	ner's Name	(First, Middle,				
Viario	ld be lenta ked ic ev	To B	Joseph Zim	nerman				Ha	nnah		Doran			
<u>=</u>	2 should be filed within 72 hours after death with the Maryland and Mertal Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Meylean Evan her must be notified at	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailii	ng Address (Street	and Numi	ber or Rura	I Route Numbe	er, City or To	own, State, Z	ip Code)	
Ě	alth a 27 Is		David Lindenbaum	/ Son		11845	Summer (Oak D	rive;	German	ntown,	, MD 20	874	
ב ב	of He item		20a. Method of Disposition	_	20b.	Place of Dispo	sition (Name of natory or other plac	ce)	D	ate	20c. Locat	tion - City or 1	own, State	
=	Page nent (int: If		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		i State		1n Crema	i i	11/03	3/2009	Brei	ntwood	, MD	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Department of the m 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantment must be notified at once.		21. Signature of Funeral Service Lice	nsee			2. Name and Addre						,	
Ď	S a la De		essy			10	040 Rockv	ille	Pike	, Rockv	ille,	MD 20	852	
			23a. Part 1. Enter the disvalle, or com shock, a leart failure List only	plications that	caused the dea	th. Do not ent	er the mode of dyir	ng, such a	as cardiac o	or respiratory a	rrest,		Approxima Interval Be	
	Physician	. 11	immediate Cause (Final disease or condition		epsis							2	Onset and 2 wee	Death
	/Medical		resulting in death)	a	(or as a conse	quence of):								TCD
	Examiner		Cognostially list conditions	Alzh	eimer's	Disea	se							
_	ב. ס	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):								
	ecute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c. Anem									Year	S
Š	oe ex	ũ	resulting in death) Last		(or as a conse								37	
0/00/	icate be executed physician and the burial-transit	dical	•	d. Aort	ic Sten	OSIS							Year	S
O X	ding ge as	/Me	IF FEMALE:	23c If was or	atcome of pregr	ancy				•				
ממ	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	birth 2 Fet gnant at time of	al death 3	Ectopic pregnanc	у			230	 Date of deli Month 	very Day	Year
5	the de	ysic	1 □ Yes 2 2XNo 9 □ Unknown	9 Unk		ueam 5L	Other (specify) _							
Ľ	that the ed by detac		Part il. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part	1.	23e. Did to	obacco use	contribute to	the cause of	death?
corns,	uires sign Id be	Completed by	Colon Cancer, Ren	nal fai	lure, 0	steopo	rosis			1 🗆 🕆	/es 2⊠1	No 3□ Pr	obably 4	Unknown
3	v req	ete	Hypertension, Ar	thritis						24a. Was	en s	24b. Were au	tonsy finding	s available
ב	he la e has ige 2	Ę.	, [autor	rmed?	prior to death?	ompletion of	cause of
9	ifficat		25. Was case referred to medical	1				OF Disc	as of Dooth	1 □Yes (Check only o	2 K No	1 ☐ Yes	2 □ No	
>	Attending Physician: The law requires that the death certificate ardeath. retoer: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	ot 3 DOA Oth	or:		me 5 ☐ Resid		Other (Spe	assis	
5	g Phy er thi	n: To	27. Manner of Death	28a. Date	of Injury	28b. Time o	28c. inju	ry at		28d. Describe I				Б
5	ath.	atio	1 Natural 5 Pending 2 Accident investigation		nth, Day, Year)	Injury	M 1 🗆	kr Yes 2□	□No					
2	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plac	e of Injury - At I	nome, farm, str	eet, factory, office		2	28f. Location (S City or To	Street and N	lumber or Ru	ral Route Nu	mber,
5	s afte	Certification:	4 - Homodo	Dunc	ing, etc. (opeo					Ony or rov	in, Olalo)			
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as						n occurred at the ti							(s)
	the H nin 24 the F	Medical	опе)		nner stated.					- T				
	P with Co.	2	29b. Signature and title of certifier	/			29c. Licens	se number			29d. Date s	signed (Montl	n, Day, Year)	
	10		7 7 1	ayto, 1	20		134	463			10/	30/09		
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			Carolyn J. Harrin	w	Destate de Olean	-4	08 Darnes	town	Koad	#A; N.	Poto	mac, M	2087 ע	8
	Stat Registra		NOV 0 3 200	9 12.	Hegistrar's Sign	bau	Les .							
			1404 0 0 200	o Herri										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) EE Nov. 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CECIL UNION HOSPITAL ELKtON If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

VIRGINIA 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1□M 2√F Days Min. 232-48-6865 1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No NEWACK NewCastle DeLAWAGE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19713 #8 Ardmore u.s.A 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LERK TYPIST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles E. Kuth E. ELLIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEWARK DOLAWASE 19713 V. LESTEP/HUSBAND #8 ARDMORE ROAD MARSHALL 20c. Location - City or Town, State
635 Chuschmans RD.
NCWARK, De. 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☑ Cremation 3 ☐Removal from State Nov. 5, 2009 UNITED CREMATORY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and A dress of Facility 635 ChurchMANS RD. StrANO+ Feelly Funeral Home NKeown NEWARKDCLAUAR 19702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer una Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other:

Injury or other

21215-0036

Maryland

Baltimore,

Director

Funeral

2

Completed the Medical

burial-trai

Examiner

Physician/Medical

2

Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

and attending physician I for use as the buria þ has certificate r this certifica within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

The law requires that the death certificate be executed

Records, P.O. Box 68760,

or Vital

Division

To the Hospital or Attending Physician:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 3 Suicide determined 4 Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, 32. Registrar's Signatur

State Registrar

6

9-08685			pe or Print in B							le.		
Albert Wayne Lou		ridge, Jr. St 1- For State Registrar	ate of Maryland		tment o <i>ificate o</i>		nd Ment	al Hygier	1 C Reg. N	20	00 2701	
Physiciar Medical Examin	n/ ier	1. Decedent's Name (First, Middl Albert Wa	yne Loughrid		r.				e of Death oth Day vember 8,	y Year 2009	3. Time of Death 1043 hrs	
		4a. Facility Name (if not institution 529 E. Baltimore Street	. •	r)		4b. City, Town, o		f Death		4c. County of Dea Carroll	th	
Funeral Director		5. Social Security Number 492–68–5094	6. Sex 7. A	ge (In yrs. las	st birthday) Yr:	If Under 1 Ye Months Da		1.6	ete of Birth(M	Fore	irthplace (State or ign Missouri country)	
wany		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loca	tion		L		-	10d. Inside City Limits	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	Maryland Car	roll			10f. Zip Code	Taney	town	10g. C	Citizen of What Co	1 Yes 2 No untry?	
ith the M		4317 Old Taney	town Road	at Ever in II S	112 W	as Decedent of H	2178		oc or No	USA	erican Indian, Black,	
or items	Funeral	1 Never Married 2 M	Armed Forces		lf `	es, specify Cuba	ın, Mexican,			White, etc.	nite	
ours afte	ŝ.	Widowed 4 Div 15. Decedent's Education (Spec	orced If Yes, Give Year or Dates: cify only highest grade co	ompleted)	16a. Decede	Yes 2 N	ation (Give k		ne 16b	Specify: WI		
036 ithin 72 h ne. r than "r fedical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				during most of working life. DO NOT use retired) Mechanic				Automobile		
215-0 e filed wittel Hygie ked other nt, the M	Be Co	17. Father's Name (First, Middle, Albert W. Loug						s Name (First, et Pars		en Surname)		
MD 21, d 2 should b ith and Men o 27 is mark	10	19a. Informant's Name/Relations Albert W. Loug			817	North 5t	th Ave	per or Rural Ro	oute Number,	City or Town, Sta A 16601	te, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygone. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other St		State Se	entalory or o	sition (Name of co ther place) . Cremato		Date 11/11/2		c. Location - City of Winfield		
Balti permit. Departin Import		2 Signature of Funeral Service		5						raw Funer own, MD 2		
xaminer	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Death		
and and tra	<u>a</u>	X unpended	dAMENDED2333	27 28	a_f ne	rMF C8	97 11/	/23/09	тт			
ing Physician: The law requires that the death certificate be extended the certificate be experient secretificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial		AMENDED 23a,27,28a-f,perME, G897 11/23/09 TT IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23a,27,28a-f,perME, G897 11/23/09 TT 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) g Unknown							23d. Date of delive Month	ery Day Year		
P.O. I s that the gned by the e detached	2	Part II. Other significant condit	ions contributing to dea	ath but not res	sulting in the	underlying cause	given in Par	1			o the cause of death?	
Division of Vital Records, P.O. as afterding Physician: The law requires that the safter death. In al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly different to the property of the property.	Completed							[4a. Was an autopsy performed ✓ Yes 2	prior to death?		
ital Riscian: 1	8	25. Was case referred to medical examiner?	[Hospital:	ient 2 E	ER/Outpatien			Check only one Nursing Home		idence 6 🗸 Oth		
on of V anding Physiath. r: After thine funeral d	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of In (Month, Day,	jury ,Year)	28b. Time of	Injury 28c. Inj	ury at Work?	? 28d. D		injury occurred	el Scelle	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	3 Suicide 6 Coul	stigation	Injury - At hon		et, factory, office	building, etc	28f. Lo	lown, State)	Rural Route Number MD ity St, Taneytow	
To the Hosp within 24 ho To the Fune completely f	ledical C		hysician: To the best of r miner:On the basis of ex- and manner stated	amination and				ce, and due to	the cause(s)	and manner as st	ated.	
WIL	₽	29b. Signature and title of certifie					.M.E.			d. Date signed <i>(N</i> ovember 9, 20		
		30. Name and address of person Pamela E. Southall, M	·			1 Penn Stree		ore, MD 21				
		31. Date filed (Month, Day, Year)	32 Regist	ar's Signature	e							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Whitacre Murray :35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 214-32-9723 1 M 2 K F Months Hours Min. Nov. 29, 1914 94 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12517 Kuhl Road 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", White 3 🔀 Widowed 4 🗆 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Ira Christie Whitacre Rachel Dorsey Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12517 Kuhl Road, Silver Spring, MD 20902 Joanne M. Richards/Daughter Department of Hea Important: If item Date 2, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 6 1 Burial 2 X Cremation 3 Removal from State 2009 injury 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signatu f Fuheral Service 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequent e of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: ᅆ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this a completed filled in by the funeral director. 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation ☐ Àccider ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year. 10 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State NOV 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Daisy Gumersinda Molina November 2009 9:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11405 Columbia Pike, Apt. Bl Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, 1 1 M 2 2 F Months Days Hours Min. Year) Director 263-74-3048 91 Jan. Cuba Usual Residence of Decedent 28a-f sho 10b. County 10c. City, Town or Location ems 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11405 Columbia Pike, Apt. Bl 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No <u>ج</u> 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1XX Yes 2 No Specify: Cuban White Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) the Homemaker Own Home Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Genaro Coya Caridad Cabero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juan Manuel Molina/Husband 11405 Columbia Pike, Apt. Bl, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛱 Cremation 3 🗆 Removal from State Nov. 2009 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death .Physician/ disease or condition resulting in death) Acute Myocardial Infarction Medical Due to (or as a consequence of) Examiner Atherosclerosis Sequentially list conditions, if any, because immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): physician s the burial Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2*X*No for Month 4 Pregnant 9 Unknown Pregnant at time of death Dav Year 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arterial Hypertension 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital မ 1 🗌 Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 8188 Nov. Oracioni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 717 Pershing Drive, Silver Spring, MD 20910 Hugo Graziani, MD 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

State

Registrar

NOV 03

2009

	1 - State Registrar					Ce	rtificate of	Death		Re	eg. No 2	009	3702	
an	1. Decedent's Nam	e (First, Midd.	lle, Last)	Evelyn	Burka N	fodance			Me	ite of Deat onth tober	Day	Year 2009	3. Time of Death 5:55 a	
al er	4a. Facility Name (i	If not institutio	n, give str			- Julius	4b. City, Town,	or Location of				ounty of Deat		
				errace, #				Bethes					ntgomery	
	5. Social Security N		6. Sex	7.A		last birthday) Yrs.	If Under 1 Year Months Days		Min. (M	te of Birth lonth, Day,	Year)	Co	thplace (State or Fore	
	578-22-768 Usual Residence of				86				Dece	ember	06,19	22 Distr	rict of Colu	
_	10a. State	10b. County	/		10c. Cit	y, Town or Lo	ocation						10d. Inside City Lim	
Director	Maryland Montgomery							Bethesd	a				1 □Yes 2 😿	
5	10e. Street and Number 5450 Whitley Park Terrace, #2						10f, Zip Code			1	0g. Citize	en of What Co		
Š D	5450 WI	hitley P		errace, # . Was Deceden		S. 13.	Was Decedent of	20814 Hispanic Orio	in? (Specify Y	es or No-	14	U.S.		
Funeral	1 Never Marri	ied 2□ Mar		Armed Forces 1 ☐ Yes 2 🔀	?		Was Decedent of If Yes, specify Cub		Puerto Rican,	etc.)		Black, White	e, etc.	
u D	3 🛂 Widowed	4 Divorced	4	If Yes, Give Year or Dates	:		1 □Yes 2 🗷 No	Specify:			S	Specify:	Caucasian	
Completed	(Spec	15. Deceder cify only highe	nt's Educat est grade d	tion completed)		(Give	dent's Usual Occu kind of work done	during most	of working	-	16b. Kind	d of Business/	Industry	
1	Elementary/Seco	ondary (0-12)		College (1-4or	5+)	ille.	DO NOT use retire Homen					Own B	lomo	
	17. Father's Name	(First, Middle,	, Last)				Пошен	T	r's Name (First	, Middle, N	Aaiden Si		TOTAL	
To Be	Meyer Burke								Fa	annie l	Korman			
- 1	19a. Informant's N	ame/Relations	ship (<i>Type</i>	. Print)		19b. Maili	ng Address (Stree	t and Number	r or Rural Rout	te Number	, City or T	Town, State, 2	Zip Code)	
		A. Bage	1 - Da	ughter			Rockhurst							
	20a. Method of Dis	•	3 □ Rer	noval from State	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other pla	ace)	Date	1	20c. Loca	ation - City or	Town, State	
	4 □ Donation						rial Garde		1/02/2009	9	01ne	y, Maryl	Land	
	21. Signature of Fu	ineral Service	Licensee	Mod	709	Há	2. Name and Addr nes-Rinald	li Funer	al Home,				. 1 . 00007	
	23a. Part . Enter t	the disease, o	r complica	tions that cause	ed the death							ing, mar	ryland 20904 Approximate	
	shock, or hea Immediate Cause	art List (Final	t only one	cause on each	line.			3,			,		Interval Between Onset and Death	
	disease or condition resulting in death)		a.	Intr Due to (or a		e Chest	Pain						3 years	
	Conventially list on	nditions	b	Shin	gles								3 years	
2	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or	mediate	Į	Due to (or a	uence of):									
Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
-				540 (0, 0	o a ooooq.	201100 01).								
earc			d											
	IF FEMALE: 23b. Was deceden		230	. If yes, outcom							23	3d. Date of del	livery	
Physician/Medic	in the past 12 months? 1 ☐ Yes 2 No 1 ☐ Horrow at time of death 5 ☐ Other (specify)											Month	Day Year	
ŕ	9 ☐ Unknown													
by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco to 1 1 Yes 2-2											o use contribute to the cause of death? 2≛ No 3☐ Probably 4☐ Unknow		
2	-								_		-	22	-012	
2									— ²	4a. Was ai autops perforn	v l	prior to death?	utopsy findings availa completion of cause	
2		red to median	u T					00 D		☐Yes 2	2 X No	1 □ Yes	2 □ No	
combiered by	25 Mas case refer	reu to medica		spital:	tient 2 🗆	ER/Outnatie	nt 3 🗆 DOA Ot	her.	of Death (Che			Other (See	noifu)	
pe completed by	25. Was case referexaminer?	No	1 ☐ Yes 2 🗷 No											
Be Completed by	examiner? 1 Yes 2 X	th		(Month C	ay, icai)	Injury		ork? ∐Yes 2. □N	10					
Be Completed by	examiner? 1 Yes 2 27. Manner of Deat 1 Natural 2 Accident	th 5 ☐ Pendir investi	ng igation	(Month, E			(reet and n, State)	Number or Ri	ural Route Number,	
Be Completed by	examiner? 1 ☐ Yes 2 🔀 27. Manner of Deat 1 👿 Natural	ih 5 □ Pendir	ng igation not be	(Month, E	njury - At ho etc. <i>(Specif</i>		eet, lactory, office		0	ny or rown				
Certification: To Be Completed by	examiner? 1 Yes 2 2 2 2 2 2 2 3 2 3 2 3 2 3 3	th 5 Pendir investi 6 Could detern	ng igation not be nined	(Month, E 28e. Place of In building, e	etc.*(Specif	v)								
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edical Certification: To Be Completed by	examiner? 1 Yes 2 X 27. Manner of Deat 1 X Natural 2 Accident 3 Suicide 4 Homicide	5 Pendir investi 6 Could detern 1 Certifyi 2 Medical	ng igation not be nined ng Physic	(Month, E 28e. Place of Inbuilding, e	etc. (Specif	wledge, dear	h occurred at the vestigation, in my	time, date and	d place, and di	ue to the c	ause(s) a ate and p		e to the cause(s)	
edical Certification: lo Be Completed by	examiner? 1 Yes 2 X 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	5 Pendir investi 6 Could detern 1 Certifyi 2 Medical	ng igation not be nined ng Physic	(Month, E 28e. Place of Inbuilding, e cian: To the best r: On the basis	etc. (Specif	wledge, dear	h occurred at the vestigation, in my	time, date and opinion, deat	d place, and di	ue to the c	ause(s) a ate and p gd. Date	olace, and due	th, Day, Year)	
Medical Certification: To Be Completed by I	examiner? 1 Yes 2 X 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	th 5 Pendir investi 6 Could detern 1 Certifyi 2 Medical	ng igation not be nined nor be	(Month, E 28e. Place of Inbuilding, of clan: To the best r. On the basis and manner.	et of my kno of examina rated.	wledge, deartion and/or in	h occurred at the investigation, in my 29c. Licen	time, date and opinion, deat	d place, and di	ue to the c	ause(s) a ate and p gd. Date	olace, and due	th, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Gerald 8:48 p Martin October 28, 2009 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/27/1921 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 X M 2 □ F Director 062-16-6054 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ▼ Yes 2 No Directo Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be r 12808 Weiss Street 20853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 No 1942 1 Yes 2 No 1942 If Yes, Give 1942 Year or Dates: 1946 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 2 Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 5+ Electronic Engineer Federal Government marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Goldberg Mildred Lowenthal 2 and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.9
Department of Health a Important: If item 27 is any injury or other trau 311 Bunker Hill Street, Fredericksburg, VA 22401 Robert Martin, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns 10/30/2009 Olney, Maryland 21. Signatura, f Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville, Maryland 20852 23a. Paul 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a managuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and burial-tran Due to (or as a consequence of) physician a Box 68760 Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9∏Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an ate has by page 2 s Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours af er deat To the Funeral Director 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0 00062435 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED EISAYTAD 1010 MaleCular Dr. Rockville, MD 20850

Registrar

State

Year)

3

(Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) P^{M} November 2009 2:10 Wayne Ralph McKee 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington County Golden Living Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours 187-20-8715 82 April 15,1927 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 90 Manor Dr. Apt. 21740 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Company Production Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John A. McKee Mabel Young McKee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Manor Dr. Apt. A1 Hagerstown, MD 21740 Jane D. McKee-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 11-10-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License Eastern_Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or a a consequence of): mphom montas disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IE EENAALE

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Hygiene. other than "natural" or items 23a or 'nette Medical Examiner must be r

sician and burial-tran signed by the a page 2 s certificate

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner

Be Completed by Physician/Medical

Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and ad hess of person who completed

	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 9 ☐ Unknown	al death 3□Ectopic			23d. Date of delivery Month Day Year				
	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death? ☐ No 3 ☐ Probably 4 🛱 Unknowr				
					24a. Was an autopsy performed? 1 Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
١	25. Was case referred to medical	26. Place of Death (Check only one)								
	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Home 5 ☐ Residence 6	ne 5 Residence 6 Other (Specify)					
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
I	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)						

7 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D28365

29d. Date signed (Month, Day, Year)

11-9-09

3H 4+1

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

State Registrar

31. Date filed (Month, Day, Year) NOV 09

se of death (Item 23a) (Type, Print)

API

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Continue of Death

		•	For State Registrar	Otato of Maryland		tificate of	Death	Reg	2009	37030	
	Physicia	an	1. Decedent's Name (First, Middle, Last, Maria Louise Mau			2. Date of Death Month November	Day Year	3. Time of Death 8:10 A M			
Š	/Medic Examin	20	4a. Facility Name (If not institution, give NMS of Hagerstown			4b. City, Town, o	r Location of Death		4c. County of Death Washington County		
	Funeral Director		5. Social Security Number 6. Sec	7. Age (<i>In yr</i> s. <i>Ia</i>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Feb. 1,	year) 1960 New	thplace (State or Foreign ountry) York	
	Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washingto	,	r, Town or Loc				10d. Inside		
	h with the 3a or 28a st be not	Funeral Director	10e. Street and Number 673 Westwood Stre		10f. Zip Code 21740			g. Citizen of What Co	ountry?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ances.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify: 			14. Race - Ame Black, Whi Specify: Wh	nite	
Maryland 21215-0036	vithin 72 ho sne. :han "natu ie Medical	Completed by	15. Decedent's Edu (Specify only highest grace Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retire ectional	during most of work d)	ing	6b. Kind of Business State Gove		
ر 2	e filed v Il Hygie other t vent, th	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)		
ylar	ould be Menta rarked	To	Nunzio Mauriello		401 44 11	111 (0)		Mauriel		Zin Codol	
Mar	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (T) Ralph Mauriello /		1	_			City or Town, State, Maryland		
Baltimore,	Pages 1 a nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	se Hill	sition (Name of natory or other pla Cemeter	y 11-10-	-2009 H	-	, Maryland	
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compshock, or hear failure. List only of	Fin	14.3)21 Fact	D1	Mossile II	To a area + ar me	neral Home . MD 21742	
5	Physician /Medical Examiner	er	st,	Approximate Interval Between Onset and Death							
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):						
.O. Box 68	The law requires that the doath certificat the has been signed by the attending phyoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year	
Δ.	quires that the signed by the detaction of the detaction of the detaction of the detaction of the significant of the significan	þ	Part II. Other significant conditions co	ontributing to death but not res	23e. Did tob 1 ☐ Ye	id tobacco use contribute to the cause of death? □ Yes					
Division or Vital Records,	: The law requir cate has been si page 2 should	Completed						24a. Was ar autops perform 1∐ Yes 2	y prior to		
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier	nt 3 DOA OI	har:	th (Check only one		necify)	
ion or	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director. After this certificate he completely filled in by the funeral director, page.	tion: To	27. Manner of Death X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj			esidence 6 Other (Specify) ee how injury occurred		
Divis	al or Atte after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,	
	e Hospital or 24 hours afte Funeral Dir etely filled in I	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or ir	h occurred at the ivestigation, in my	time, date and place opinion, death occu	e, and due to the ca urred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To the land within 24 To the I	Mec	29b. Signature and title of certifier	\wedge	01	29c. Licer	nse number		9d. Date signed (<i>Mo</i>	nth, Day, Year)	
	11 11 N		3 Name and address of person who	completed cause of death (Iter	n 23a) (Type,		5 148		1 1 1		
0	יו אכ		NM3 Healthcare of 31. Date filed (Month, Day, Year)	Hagerstown Y 32. Begistrar's Signa	14014 ature	- Marst	Pike He	agerstown	n, MD 21	742	
	St Regist	ate rar		009	1 1	and					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0 4a. Facility Name (If not institution, give street and number) MARIE MASORS /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCESS 12360 PALMETTO CHURCH SOMERSET 3. Date of Birth (Month, Day, Year) 6-21-19 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number **Funeral** 1 □ M 2 🕶 Hours Director OHIO 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp. it we must be redified at SALISBURY 101. Zip Code Director 1 Tes 2 No M Wicomico 10e. Street and Number 10g. Citizen of What Country? 2180 DOVER ST. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be flied within 72 hours after of Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or iter any Injury or other traumatic event, its Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ NO Specify. 3 ₩idowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COSMETICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NEWEL PERNA CHEESMAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KOBERT JOHN MASURS (SON) HOW ELLYILLE AD PITISHILLE, MD 2/850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Athol Baptist Church (101/10-31-09 21. Signature of Funeral Service Licensee 23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MESSICK FUNETAL HOME PO GOXGI BIVALVE, MD 21814 Immediate Cause (Final disease or condition resulting in death) **Physician** END /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be execut burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas page certificate l performe of Vital 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Norther (Specify) After this of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Division 1 Natural
2 Accident 5 Pending after death. neral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 Franklin Ave, suite 104 Berlin State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 37032 Certificate of Death Rea, No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Verlin Elliott Marshall 2009 November 1239 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital of Cecil County Elkton 8. Date of Birth (Month, Day, Ye Feb. 28, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 941 Days Hours 1****∑M 2□F Virginia 224-54-7112 68 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at Cecil Port Deposit Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21904 U.S.A. 232 Water Wheel Drive Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Du Pont than Elementary/Secondary (0-12) College (1-4or 5+) Wilmington, Delaware Power House Mechanic Twelve Years tt of Health and Mental Hyg If item 27 is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Sylvia Dickens Thomas Marshall ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 Water Wheel Drive, Port Deposit, MD 21904 Darlene Marshall Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place West Nottingham Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Page Department o Important: If any injury or 1 Durial 2 □ Cremation 3 □ Removal from State 11/09/09 Colora, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Lee A Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications at caused the death shock, or heart failure. List only one caus on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, aftending physician Physician/Medical as yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown ģ Partil, Other significant conditions contributing to death but not resulting in the underlying cause given in Partil. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has page 2 autopsy performer Yes 2 D 1 ☐ Yes Hospital or Attending Physician: 14 hours after death. Funeral Director, After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ğ 1 Yes 2 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours or the Funeral Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiet completely (Chéck only one) and manner stated. within 7 29c, License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 30 Name and addre completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar a-c, FH, TCHD, 11/2/09, rk Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1040 AM Rudolph Mobley tober 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, of Location of Death **Examiner** at Easton Hospital Memorial 00 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours Min 261-15-8539 Director 57 05-22-1952 Florida Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. Talbot 28a-f Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 August Street "natural", or items 23a 21601 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rudolph of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Allen Foods Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ဥ Henry Mobley <u>Mamie</u> <u>Lee Galloway</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Mobley/wife 518 August St., Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place).
Direct Crematory L. Thomas Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If ite any Injury or ot once. 11/02/09 10-31-09 1 Burial 2 D Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dover, DE St. Michaels, Md. 22. Name and Address of Facility 21. Signature of Funeral Servicenses Bennie Smith Funeral Home eet, Easton, Md. 21601 used the death. Do not enter the milde of dying, such as cardiac or repiratory arrest, the line 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ex-Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) o 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1 ☐ Yes 2 1NO the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 69 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rober S. WASHINGTON 57 EASTON

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 37034 Reg. No. Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Dav Yaar Physician Frances Henrietta Meadows 6:45 A.M. November 9, 2009 /Medical 4b City Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F Director 029-14-2982 85 May 2, 1924 Massachusetts Usual Residence of Decedent deeth with the Merylend 10c. City, Town or Location 10d. Insida City Limits 10a State 10b. County permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryler Department of Health end Mentel Hyglene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examenar must be notified at pares. 1K Yas 2 □ No Director MD Garrett Grantsville 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 74 Killdeer Lane 21536 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: white Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Bureau of Elementary/Secondary (0-12) Collega (1-4or 5+) Engraving & Printing 8 th Bindery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fethar's Nama (First, Middle, Last) Be John Krol Blanche Ukleja 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) James K. Meadows/husband 74 Killdeer Lane, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park Nov 11,2009 Elkridge MD 22. Nama and Address of Facility Newman Funeral Homes, P.A. 21. Signatura of Funeral Service License 179 Miller St., Box 275, Grantsville, MD 21536 euma 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Betwaen Onsat and Death Physician Immediate Cause (Final disaase or condition resulting in death) /Medical mon Examine Dua to (or as a consaquance of) Physician/Medical Examiner ettending physicien end for use es the buriel-trensit To the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consaquanca of) 23b. Did tobacco usa contributa to tha causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Tes 2 XNo 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatiant 2 | ER/Outpatiant 3 | DOA Other: Wursing Home 5 Pesidence 6 Othar (Specify) မှ 1 Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of Certification: Netural 2 ☐ Accident 5 Pending 1 ☐ Yas 2 XNo within 24 hours efter deeth.

To the Funeral Director: All completely filled in by the fu invastigation 3 ☐ Suicida 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, daath occurred at the tima, date end place, and due to the cause(s) and manner as statad. 29a. Certifier edicai 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1254E00 Nov. 10, 2009 12 30. Name and addrass of person who completed cause of death (Item 23a) (Typa, Print) Robin Bissell, DO, 124 Miller St., Grantsville, MD 21536 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State NOV 1 2 2009 Tarks Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For AMEND#10dberFH, 11, Registrar AMEND#23a/b, per	State of Mary	rland / Depa	artment of H			jiene leg. No. 200	00 07005
			1. Decedent's Name (First, Middle, Last)	MD,11/5/09,B	W,Mcco	imouto or a		2. Date of Dea	th CU	3. Time of Death
	Physicia /Medic		LILLIAN D	MELVINA NE	WMAN			oct. 26	, 2009 Ye	5:19 A M
	Examin		4a. Facility Name (If not institution, give s	street and number)			Location of Death		4c. County of D	
æ .			17812 Washington			Gaith If Under 1 Year	ersburg	To Discontinuo	MONIC	
	Funeral Director		5. Social Security Number 6. Sex 1 C	144 WEIT	0 Yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 13	Year) 9.	Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	ō	MD Montgar			hersburg				1- ∑ ¥ee 2 ∑ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code		,	10g. Citizen of What	Country?
	th with		17812 Washington	ı Grove Lan	e	208	77		U.S.A.	
٥	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modical Experience Luist by northed at	by Funeral	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 25 No If Yes, Give	· ·	Was Decedent of H If Yes, specify Cuba 1 □Yes 🎎 No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
2-0036	2 hours iatural"; ical Exc		32 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a. Dece	dent's Usual Occup	ation	life a	16b. Kind of Busine	
	vithin 7 sne. than "n	Completed	(Specify only highest grade	College (1-4or 5+)	life. I	DO NOT use retired	1)	king	TT	
N D	filed Hygi Sther	a	17. Father's Name (First, Middle, Last)			Domesti		ne (First, Middle,	Home Maiden Surname)	
/land		To B	Howard Dyson				Lou	ise Hawk	ins	
Mar	permit. Pages 1 and 2 should bu Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en once.	ľ	19a. Informant's Name/Relationship (Ty) Audrey Tyler (Daug			,			r, City or Town, Stat ille, MD	
altimore,	ages 1 a nt of He t: If item / or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, crer Brooke	sition (Name of patory or other place	re)	Date	20c. Location - City	
altin	rmit. Papartme portant portant y injury		4 ☐ Doration 5 ☐ Other (Specify) 21. Signat IV of Funeral Servic. License	1//	\Stewart	town Cem	110/3.		Gaither MERAL HOM	
מ	99 E E 9	10	Genege 1	Jeraca-	// 55				ville, M	
4	Physician	ř II	23a. Part 1. Enter the dispase, or compile shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	deal. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as a co	ensequence of):		SE-			
	D #	ner	Sequentially list conditions,	Landlor Law to (or se a co		ry Failur				
	xecuter and Il-transi	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):					
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Vital	sician: The law s certificate has b irector, page 2 s	င္ပ	25. Was case referred to medical				26. Place of Dea	1 □Yes	2 X No 1 □	Yes 2□No
<u>-</u>	ysicia is cert direct	To B	evaminer?	lospital: 1 🔲 Inpatient	2 ER/Outpatier	nt 3 DOA Oth	or:		lence 6 □Other (Specify)
Sion of	nding Ph th. : After thi e funeral		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time o	f 28c. Injur Worl			now injury occurred	
DIVIS	To the Hospital or Attending Physician: The Is within 24 buts after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
/	e Hospita 24 hours e Funera letely fille	Medical C		sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in					
5	To th within To the compl	Me	29b. Signature and Ittle of certifier			29c. Licens	e number		29d. Date signed (M	
			> VIIs and	mo		D40	869		10/27/0	19
			30. Name and address of person who co	•			7	n+a-m:	, 77; 11-~-	MD 20006
-	Sta	to.	Anoma Bandara, M.I 31. Date filed (Month, Day, Year)). 19241 M	ontgomer Signature	y village	Ave, Mo	ntganery	village,	MD 20886
	Sta Registr		NOV 0 3 2009	Person	Signature for	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item # 6 State of Maryland / Department of Health and Mental Hygiene
Tjw

Certificate of Death

Reg. No. 2009 Cecil Co. For Health Dept. rjw 37036 11/05/200 degistrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 3, Lillian В. Nu11 2009 5:20 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2375 Old Field Point Road Ceci1 E1kton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min Yrs 16, Delaware 220-18-4502 1918 Dec. Director 90 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm W. dical Examinating to motified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2375 Old Field Point Rd. USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Sample Maker Textile is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Lenora Sidwell Delaware Gregg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Harold H. Null, Jr./Son 242 Fair Hill Dr., Elkton, MD 21921 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 X Cremation 3 ☐ Removal from State 11-06-2009 | Newark, Delaware Newark Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R.T. Foard & Jones, Inc.
122 West Main St., Newark, DE re of Funeral Service Licenses ichaig 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition

a. Charter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Charter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Obstructive Pulmonory Discouse Physician ansagan disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it had a so or injury Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Year Day 5 Other (specify) P.O. hed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ficate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy Hospital or Attending Physician: The performed? Yes 2 No 1 ☐Yes 2 ☐No 1 □ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11.3.2009 & achder 5 Mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S SACHDEV MD, 126 A, E + Ligh ST, EChton MD 21921.

31. Date filed (Month, Day, Year)

32. Registrar's Signature State Bereva B. park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Month Year 3009 Andrew John Narel, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DIO Under 1 Year If/Under 24 Hrs. Sex 1 X M 2 ☐ F 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days 061-14-7931 90 Yrs. 30. 1919 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Delaware Sussex Rehobeth Beach 10e. Street and Number 10g. Citizen of What Country? Landing 19971 17 Eagles USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1949–53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Racetrack Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Narel Evelyn Hizenski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Landing, Unit #2, Andrea Odell/Daughter Eagles Rehobeth Beach. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11-06-2009 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21911 Approximate Interval Between Onset and Death Immediate Cause (Final 52050 disease or condition resulting in death) าบหมดอย Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name Knum TO Physician: NAREL, Andrew Jihr Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Examiner the death certificate be executed and -trar burial-1 Physician/Medical

Box 68760

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of Vital Records,

Physician

/Medical

Examiner

Funeral

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Funeral

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Pages 1 and 2 should

attending physician for use as the buria signed by the a cate has certificate director, this

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Completed

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Medical Certification: To

The law requires that Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral .

SHVA

State Registrar

(Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of d

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states

VA Markad Health

29c. License number

29d. Date signed (Month, Day, Year)

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Kerithanom -31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier

32. Registrar's Signat

NOV 0 5 2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:53 AM 26 2009 OUT MARK HAYDIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner HOWARA COUNTY General HOSPITA HOWARD 6. Sex M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Director 219-74-3870 Usual Residence of Decedent 7/5/64 MD death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinational by notified at once. 10a. State 1 ☐ Yes 2X No Director MDMontgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9164 Centerway Road 20879 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 AFR Furniture Rental <u>Warehouse Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Hardin Riggs Catherine Cordella Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Riggs - wife 160 Heathfield Drive, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 11/5/09 Hanover, MD 22. Name and Address of Facility Snowden Funeral Home Sign ture of Funeral Service Ligensee T246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONDUANY ATherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown CArpio my opa Thy 24b. Were autopsy findings available prior to completion of cause of death? Ityper PRNSION 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the horizottem.

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MICHAEL State Registrar

Medical

2 Accident

4 ☐ Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

6 ☐ Could not be

determined

and manner stated.

1 ☐ Yes 2 ☐ No

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name any ddress of prison who completed cause of death (Item 23a) (Type, Print)

5755 Cedar LN COLMBIN MO 21044

PERLINE, COM 31. Date filed (Month, Day, Year) 22. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of M	aryland / [Department of Certificate	of Health and I		ene 2009	37039
	Physici		1. Decedent's Name (First, Middle, L	ast) RANK	Redde			2. Date of Death	Day Year	3. Time of Death
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e de la companya de l	Funeral Director		216-38-8956	Sex 7. Ag	-	thday) If Under 1 Your Months Do	ear If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birth	place (State or Foreign of try)
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:	or 28a-f	Director	10e. Street and Number	mier	SA	10f. Zip Co	de	100	g. Citizen of What Cou	1. ☑Yes 2 □ No ntry?
i	ns 23a c	Funeral D	40 / 18, Wity (1	12. Was Decedent	Ever in U.S.	13 Was Decedent		pecify Yes or No-	14. Race - Ameri	can Indian
0000	rai", or Iten	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	No	If Yes, specify of 1 □ Yes 2万	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	Ricen, etc.)	Black, White,	
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yiand	Mental Hygi	To Be C	17. Father's Name (First, Middle, Las	den			18. Mother's Nam	ne (First, Middle, Ma	E	
2	dealth im 27 ther to		19a. Informant's Name Relationship NWE SE OSON 20a. Method of Disposition Burial 2 □ Cremation 3	- NiECE	6 5	Mailing Address (St. 105 Dud Disposition (Name of y, crematory or other	blE. Beide	E Rol	City or Town, State, Zip	Me aire
	Department of home of the partment of home of the partment of the any injury or of once.		4 Donation 5 Other (Special Signature of Funeral Service Lice	ify)	Md UF	22. Name and A	11 -	5-09	tuelock,	mcl .
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	hysician /Medical		23 . P. v. 1. Enter the disease, or con a lock, or heart failure. List onl have diate Ceuse (Final disease or condition resulting in death)	a. Cert	a consequence of	canc	oying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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The law requires that the death certific	by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 ☐ Ectopic pregr 5 ☐ Other (specif			23d. Date of deliver Month	ery Day Year
equires that I	s been signed by should be deta	þ	Part II. Other significant conditions	contributing to death be	ut not resulting in	the underlying cause	given in Part I.	23e. Did toba	cco use contribute to to	ne cause of death?
		Completed						24a. Was an autopsy performe 1 □ Yes 2 [prior to co	psy findings available mpletion of cause of 2 No
vsiciar	this certifica al director, pi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	tpatient 3 □ DOA	Other:	th (Check only one)	ce 6 ☐ Other (Specia	(v)
Attending Physician:	th. : After th s funeral	tion: 1	27. Manner of Death 1	28a. Date of Inju (Month, Day	ry 28b. T y, Year) Ir		njury at Vork? 1 □ Yes 2 □ No	28d. Describe how		,
tal or Atte	# Sign	Certification:	3 Suicide 6 Could not lead to determine determined		Iry - At home, far c. <i>(Specify)</i>	n, street, factory, offi	ce	28f. Location (Stre City or Town,	et and Number or Rura State)	N Route Number,
To the Hospital	e Funer	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	, death occurred at the d/or investigation, in r	e time, date and place ny opinion, death occu	, and due to the cau rred at the time, date	ise(s) and manner as s e and place, and due to	stated. o the cause(s)
Toth	To th comp	Me	29b. Signature and title of certifier	All		29c. Lio	ense number	9 290	I. Date signed (Month,	Day, Year)
1	NA		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)	1017		1 39	0/
	Stat	te	31. Date filed (Month, Day, Year)		10, 2 ar's Signature	000	VICHVO	SA	1:SDUK	y. md
	Registra	ar	NUN U 3	2000 🗗 🗸	M. A. M.	MARAKA			,	/

Physiciar /Medica

1 - State Registrar		Pertificate of I			Reg. No	7007	37040				
1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Da	y Year	3. Time of Death				
Louis Barry Riani 4a. Facility Name (If not institution, give street and number)		4h Oite Town	I assting of Dooth	Novemb		2, 2009	5:50 p M				
	1	_	Location of Death			. County of Deat ontgomer					
Montgomery General Hospita 5. Social Security Number 6. Sex 7. Age	L e (In yrs. last birthd	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			_				
072-26-3308 1 □XM 2 □ F Usual Residence of Decedent	74 Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da July 26	y, Year)	935 New	thplace (State or Foreign ountry) York				
10a. State 10b. County	10c. City, Town or						10d. Inside City Limits 1 ☐ Yes 2 ☐XNo				
MD Montgomery 10e. Street and Number	Silver S	Spring 10f. Zip Code			10~ 00	tizen of What Co					
3531 Tarkington Lane		20906			USA		untry				
11 Marital Status 12, Was Decedent E	Ever in U.S. 1	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No		14. Race - Ame	erican Indian,				
Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ N	1954–56	If Yes, specify Cuba 1 □Yes 2 XNo	Specify:	Rican, etc.)		Black, White Specify: Whi					
15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup live kind of work done of fe. DO NOT use retired	ation during most of work	ing	16b. K	ind of Business/					
Elementary/Secondary (0-12) College (1-4or 5-	+)	lear Engine			Fed	eral Gov	vernment				
17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden	Surname)					
Louis Joseph Riani			Dorothy 1	Marie Ba	arry						
19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street									
Angela P. Riani/wife		Tarkingto									
20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sposition (Name of crematory or other place of the place ourney crem		Date /04/09		ocation - City or dbine, I					
21. Signature of Funeral Service Licensee	MO1 251	22. Name and Addres	S CRemation	on Serv	ice	P.O. Bo	ox 784 le, MD 21029				
23a. Part 1. Enter the disease, or complications that caused	the death. Do not					arkbyii	Approximate Interval Between				
shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ab SCE 35.											
Due to (or as a	a consequence of):	1 . 1 0									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	consequence of):	ACIDO	73.								
cause. Enter Underlying Cause (Disease or injury that initiated events c. Pro	umoni	Č-									
resulting in death) Last Due to (or as a	a consequence of):	u'luxe									
d. Reno	el to	ulure									
IF FEMALE:											
23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	<i>y</i>			23d. Date of del Month	livery Day Year				
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	time of death	5 Uniter (specify) _									
Part II. Other significant conditions contributing to death but	t not resulting in the	e underlying cause give	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?				
				1 🗆 '	Yes 2	□ No 3□ Pi	robably 4 Unknown				
				24a. Was		24b. Were au	utopsy findings available				
				auto _l perfo 1 □ Yes	psy rmed? 2 No	death?	completion of cause of 2 □ No				
25. Was case referred to medical examiner?			26. Place of Deat								
1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpa	atient 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 ☐ Resi	dence	6 □ Other (Spe	ecify)				
27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day	y 28b. Time (, Year) Injur	ry Work	?	28d. Describe	how inju	ry occurred					
2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □ No								
4 Homicide determined building, etc	ry - At nome, tarm, . <i>(Specify)</i>	street, factory, office		City or To	Street ar wn, State	nd Number or Hi e)	ural Route Number,				
29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examination and/o	eath occurred at the tir or investigation, in my o	ne, date and place pinion, death occur	and due to the red at the time,	cause(s date an	s) and manner a d place, and due	s stated. e to the cause(s)				
29b. Signature and title of certifier		29c. License	e number		29d. Da	ate signed (Mont	th, Day, Year)				
(Yan' Mi)		Dog	06802	6	1	1/2/:	2009				
30. Name and address of person who completed cause of de PACMAJA BANd: M. D. 18	eath (Item 23a) (Typ	pe, Print) nce Phill	ip br.	Olney	MD	20837					
31. Date filed (Month, Day, Year) 32. Begistra	r's Signature										
NOV 0 4 2009 Senser	N B. X	parker									

State Registrar

1511

			1 _ State	State of M	-	epartmei C <i>ertifica</i>			id Mental H			07011
II.			Registrar 1. Decedent's Name (First, Middle, Last)			Jertinoa	01 2	Jean	2. Date of I	Reg. No	2009	3. Time of Death
300	Physicia	an		Damba					Month Novemb	er 3	2009 Year	01:00 AM
1	/Medic		Beulah E.G. 4a. Facility Name (If not institution, give st			4b. City	, Town, or	Location of D			. County of Deat	
P	Èxamin	er	Union Hospital of				E1ktc	n			Cecil	
- **	Funeral	40	5. Social Security Number 6. Sex		ge (In yrs. last birth	day) If Unde	r 1 Year	If Under 24	Hrs. 8. Date of E	Birth Day, Year,	Q Rint	hplace (State or Foreign
	Director		216-01-8027	M 2∏F	99 ^Y	rs. Months	Days	Hours	Min. (Month, I	2, 19	10 Vir	_{uintry)} g inia
	70		Usual Residence of Decedent									40d Incide Oite Circles
	arylar show	_	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits 1 □Yes 2 X No
	8a-f s	Director	Maryland Cecil		Nort	h East				10.0		
	vith th	Ë	10e. Street and Number			101. 2	p Code				tizen of What Co	
	s 23a	iral	630 Mechanics Val	Ley Road 2. Was Decedent	Ever in II C	12 Was Dag	2190		? (Specify Yes or I		ited Sta 14. Race - Ame	
	item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces:	?	If Yes, sp	ecify Cuba	in, Mexican, I	Puerto Rican, etc.)	10-	Black, White	
36	Ir's af	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	110	1 ☐ Yes	2 X No	Specify:			Specify:	White
Ö	2 hou atura	ted	15. Decedent's Educ		16a. i	Decedent's Us	ual Occup	ation		16b. h	(ind of Business/	Industry
7	nin 7% In "ni Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or		Give kind of w life. DO NOT	ork done d use retired	during most o f)	t working			
7	d with	E O	12	2		recutiv	e Seç	retary	у		Chemica	1
g	be filed within 72 hours after death with the Marylar ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Midd	lle, Maidei	n Surname)	
<u>a</u>	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	2	Glenn G. Edward	ds				Meli	ssa Poe			
Maryland 21215-0036	2 should be filed and Mental Hygi Is marked other aumatic event, th		19a. Informant's Name/Relationship (Typ				,		or Rural Route Nur			
	and lealth m 27 her tu		Mary Moyer / Daugl	nter	1			•			ocation - City or	ryland21901
0	ages 1 and 2 should bent of Health and Ment t: If item 27 is marked y or other traumatic e		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	emoval from State	20b. Place of cemeter. North	, crematory or CastMet	other place	e) No	ovember		•	
altimore,	t. Pa tmen tant: ijury	- 74	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer → e → e License		L.o. C.				, 2009			Maryland
Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot		21. Signature of Funer Service License	>		1			Crouch F			ry1and21901
			23a. Part1. Enter the disease, or complic	eations that cause	d the death. Do no						Lase, Ha	Approximate
L			shock, or heart failure. List only on Immediate Cause (Final	e cause on each I	line.		, , , , ,	9,	,	,		Interval Between Onset and Death
5	Physician /Medical		disease or condition resulting in death)	Dunta (are	ute MI	F).						unknown
	Examiner			Due to (or as	s a consequence o	blee	d					
		-	Sequentially list conditions, b.	Due to (or as	s a conse juence o							
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ó	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	s a consequence o	f):						
8760,	cate be executed physician and the burial-transit	dical	d.									
Ó	rtifica ng ph as th	Ned	IF FEMALE:							- 1		
Box	death certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 □ Live birth	e pf pregnancy 2 Fetal death	3 □Ectopic	pregnancy	/			23d. Date of del Month	livery Day Year
	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of death	5 ☐ Other (specify)			-	month.	Duy
<u>Ч</u>	d by t	Physician/Me	Part II. Other significant conditions con	tributing to death	but not reculting in	the underlying	cause div	en in Part I	23e Di	d tobacco	use contribute to	the cause of death?
Vital Records, P.O.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	þ	Cardial dis	0050	but not resulting in	the directlying	odddo giv	on mir air i.		☐ Yes		
0	requ	sted		<u> </u>								
ec Sec	e law has t	Completed			-				24a. W	as an itopsy erformed?	prior to	utopsy findings available completion of cause of
a	n: Th icate r, pag		-						1□ Ye	s 2 N		2 🕱 No
\frac{1}{2}	siclar certif	Be	25. Was case referred to medical examiner?	ospital:			OA Oth	or.	of Death (Check on		a Tau (2	"
ō	Physral di	. To	1 ☐ Yes 2 ☐ No	28a. Date of Inj			28c. Injur Wor	4 L INUIS	ing Home 5 ☐ R		ury occurred	есту)
Division or	ding th. : Afte	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Ir	ijury M		k? Yes 2⊟No	5			
/ISI	Atter	fica	3 Suicide 6 Could not be determined	28e. Place of ir	njury - At home, far etc. <i>(Specify)</i>	m, street, facto	ry, office		28f. Location	(Street a	and Number or R	ural Route Number,
á	at or A s after il Dire	Certification:	4 Homiciae	bullaing, 6	етс. (<i>Specity)</i>				City of	Tòwn, Sta	<i>(e)</i>	
	lospital t hours uneral ely filled		29a. Certifier 1 Certifying Phys	ician: To the bes	t of my knowledge of examination and	death occurre	ed at the ti	me, date and	place, and due to to occurred at the tin	he cause(ne, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physiclan: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached	Medical	one) 29b. Signature and title of certifier	and manner s				e number			ate signed (Moni	
	5 × × 0	_	11 04	1//			T	1011	17		11-7	2
			30 Name and oddress of stars with an	mileted source of	death (Itom 22a) /	Type Brist\	JX	rade c	15		1/2/00	1
			30. Name and address of person who co	106 F	CA CA	Elkt	00	MIN.	21921		,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	UINI	U,) !	ا است	2011001			<u></u>
	Regist		NOV 0 5 2009	Reserve	A. ba	Man !						

DHMH 17 Rev 1/2001

		For State	State	of Marylar			of Health of Death		lental Hy	giene	2009	37042
		Registrar 1. Decedent's Name (First, Middle	e. Last)			inicate	OI Death		2. Date of De			3. Time of Death
Physic /Med		Carol	Ann	Silverm	an				Nov 10	Day	9 Year	4:18am M
Exam		4a. Facility Name (If not institution Dove House -					own, or Location				County of Death	1
Funera Directo		5. Social Security Number 130~46-1598	6. Sex 1 ☐ M 2 ½ F	7. Age (In yrs.		If Under 1		r 24 Hrs. Min.	8. Date of Bi (Month, D May 26	rth	9. Birth	place (State or Foreign Intry) W York
ъ		Usual Residence of Decedent				}			riay 20	, 19.		
Marylar -f show	tor	Maryland Fred	erick		ty, Town or Lo lonrovi							10d. Inside City Limits 1 □ Yes 2 X No
Deficient (1976) Mary finding Z 1 Z 1 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhal method prottled at once.	Funeral Director	10e. Street and Number 3842 Chaucer	Court			10f. Zip C	21770			-	en of What Cou	intry?
er death	unera	11. Marital Status	12. Was De	cedent Ever in U	l.S. 13. \	Vas Deceder f Yes, specify	nt of Hispanic Or Cuban, Mexica	rigin? (Spe	ecify Yes or No Rican, etc.)	т-	4. Race - Ameri Black, White,	
ours afte	₽ P	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∏Yes If Yes, G Year or		1	1 □ Yes 2]	No Specify	r.			Specify: Wh	ite
nin 72 h e. In "natu Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	(Give	DO NOT use	done during mos retired)		0		d of Business/Ir	
iled with Hygiene Hygiene ther tha nt, the		17. Father's Name (First, Middle,	4	(1-40/ 37)	Deput	ty Dir	ector -		erce (First, Middle			vernment
should be fund Mental I	To Be	George	Lasij	Web	ber			Marga		, maigerra	Newe	:11
and 2 she ealth and m 27 is m	P	19a. Informant's Name/Relations Bob Silverman		1	1	•	Street and Numb					
es 1 ar of Hea		20a. Method of Disposition 1 ☐ Burial 2 【XCremation		20b. I	Place of Dispos cemetery, cren				ate		ation - City or T	
nit. Pages artment of ortant: If its injury or o		4 □ Donation 5 □ Other (S	pecify)	Sm								, Maryland
permit. Departr Departr Imports any inje		* College	deser		706 110	<i>)</i> 6 Eas	Address of Facility & Basi t Churcl	n St,	Frede	rick,	l Home <u>Maryl</u> a	nd 21701
Physician		23a. Part 1. Enter the disease, or shock, or heart fallure. List Immediate Cause (Final	complications that only one cause on	· \	th. Do not ent	er the mode	of dying, such as	s cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to	o (or as a conseq		c can	unio.	yean	M			1109
₽ .∺	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that is interested to the conditions)	b	i (ur às a cunsau	juinee of):						1	
execute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conseq	quence of):							
icate be executed physician and the burial-transit	dical		d	•								
	In/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Ectopic pre				23	3d. Date of deliv	very
at the deal by the att	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		gnant at time of		Other (spec					Month	Day Year
es the	þ	Part II. Other significant condition	ns contributing to	death but not res	ulting in the ur	nderlying cau	se given in Part	I.				the cause of death?
w requir	Completed								24a. Was		No 3☐ Pro 24b. Were aut	opsy findings available
The law cate has I page 2 s	Comp								auto perfe 1 □ Yes	psy ormed? 2 100	- death?	ompletion of cause of
nysician: The nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Ilmantinut O.	LED/Outs-tis-		Othor:		(Check only		*	ity) DOVE her
ding Phy h. After this funeral d	⊢	27. Manner of Death 1 Matural 5 Pending	28a. Date	Inpatient 2 e of Injury nth, Day, Year)	28b. Time of Injury		☐ 4☐N :. Injury at Work?		me 5 Res 28d. Describe		Other (Spec occurred	ity) POVE NOVY
Attendii death. ctor: A y the fu	Certification:	2 Accident investig	jation	e of Injury - At h		M eet, factory, o	1 □ Yes 2 □		28f. Location	Street and	Number or Ru	ral Route Number,
	Certi	4 ☐ Homicide determ	build	ding, etc. (Speci	fy)				City or To	wn, State)		
To the Hospital or Attendin Within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To th Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	n occurred at vestigation, ir	the time, date a n my opinion, de	nd place, ath occurr	and due to the red at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	10	0 1 4		29c. L	icense number			29d. Date	signed (Month	
)		30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Tvpe. I	Print)	00643	47			1/10/0	99
		Robert L. Rice	e, MD, 55	5 South	Center	· ·	et, West	tmins	ter, M	aryla	nd 2115	7
St	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	Land .						

4

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 **Physician** YVONNA PEARL SMALLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4LLEGAN -WMHS MEMORIAL 405PITAL 8. Date of Birth (Month, Day, Year, 11–17–1938 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MARYLAND 1 □ M 2 XX 70 Director 202-30-0152 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the "Medical Event net out by notified at 1 ☐ Yes 2 📉 No Director PA BEDFORD **ARTEMAS** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 440 SILVER MILLS ROAD 17211 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2XX Married 1 □Yes 2 No WHITE Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CABINET MAKING INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY L WIGFIELD ADA MILLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED G SMALLEY 440 SILVER MILLS ROAD ARTEMAS PA 17211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FAIRVIEW CEMETERY 11-5-2009 ARTEMAS 22. Name and Address of Facility ZIMMERMAN & SON FUNERAL HOME INC 21. Signature of Funeral Service Licensee arten 45 S. CARLISLE ST. GRRENCASTLE PA 17225 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quantially list condition Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐No 24a. Was an 2 ANO 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of cartifier 29d. Date signed (Month. Day. Year) s of person who completed cause of death (Item 23a) (Type, Print) DR ZAMAN 600 MEMORIAL AVENUE CUMBERLAND MARYLAND 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 1 8 2009

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	Ce	ertificate of			2009	37044
ı	Physici /Medic		1. Decedent's Name (First, Middle, La Leonard Edward	,				2. Date of Deat Month Novemb	Day Year	3. Time of Death 12:45 a ^M
1	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	h
-107	•		Montgomery Hosp	ice-Casey	House		ockville			ntgomery
	Funeral Director		220-20-3096	Sex 7. Age	e (In yrs. last birthday 82 Yrs.	Months Days		8. Date of Birth (Month, Day, June 1		hplace (State or Foreign untry) aryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	to	Manual and Manua	~~ m o m***	Pos	ckville				1. TaYes 2. □ No
	1 the	irec	Maryland Mont	gomery	ROC	10f. Zip Code		1	0g. Citizen of What Co	untry?
	h with	Funeral Director	4810 Topping R	oad		208	52		USA	
	deat	ıner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
21215-0036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show deal Ever her increase to confined at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ N If Yes, Give Year or Dates:	lo	1 □Yes 2 🙀 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		White
5-0	72 hc	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giv	edent's Usual Occu e kind of work done	during most of work	ing	16b. Kind of Business/	Industry
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire	,		2.7	•
d 2	filed withi Hygiene. ther than		17. Father's Name (First, Middle, Last	4	Aı	rt Direct	18. Mother's Name	e (First, Middle, N	Advertis Maiden Surname)	ing
Maryland	ould be fi Mental I arked of atic eve	o Be	Burnett Ernest				Pauline 1	,	,	
Z	2 should and Mer is marke aumatic	욘	19a. Informant's Name/Relationship		19b. Mail	ling Address (Stree			, City or Town, State, 2	Zip Code)
	1 and 2 a Health a em 27 is		Lucia Ford Stro						11e, MD 20	
Baltimore,	ages ent of nt: If it		20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of Disp cemetery, cre Parklawr	osition (Name of ematory or other pla n Memoria	l Park 20	Date v. 4, 009	20c. Location - City or Rockville	
Balti	permit. F Departm Importar any Injur		21. Signature of Funeral Service Lice		Í	Name and Addr Trancis J 500 Unive	ess of Facility Collins rsity Blv	Funeral	Home Inc. ilver Spri	ng, MD 20901
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only			nter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		tic Lung (Cancer				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):					
2	Examiner		Sequentially list conditions.	b	24					
2	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
レ -	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c	a consequence of):					
68760,	s be e sician buria									
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P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attending rial director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of de Month	livery Day Year
	that t led by detac		Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
of Vital Records,	juires n sigr lld be	d by	Atrial Fibrilla	tion				1 □ Y€	es 2 No 3 P	robably 4XXJnknown
00	aw requir s been si s should b	Completed						24a. Was a	n 24b. Were at	utopsy findings available
æ	: The law cate has page 2:	l iii						autops perforr	ned? death?	completion of cause of 2 □ No
ita	ian: The rtificate tor, pag	Be C	25. Was case referred to medical				26. Place of Deat			2 🗆 140
f V	nyslci nis cer direct	TO E	examiner? 1 ☐ Yes 2 【 X No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	ent 3 DOA Ot	her: 4 \(\sum \) Nursing Ho	ome 5 ☐ Reside	ence 6 Other (Spe	Hospice
O L	ding Ph n. After th funeral	i.i	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y, Year) Injury	of 28c. Inju	ıry at rk?	28d. Describe ho	ow injury occurred	
Sio	Attending r death. ector: After by the funer	cati	2 Accident investigatio]Yes 2□No			
Division	al or Attencs after death	Certification:	4 Homicide determined		ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 ★ Certifying P 2 ★ Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occur	, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	15+1	Ž	29b. Signature and title of certifier J - Kevely C	hou, n	10		se number 3747	2	9d. Date signed (Moni	th, Day, Year) ber 2, 2009
	1-1.		30. Name and address of person who Jocelyne Kouatc	completed cause of d	eath (Item 23a) (Type 355 Piccas	rd Drive,	Rockvill	e, MD 20	850	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2009	32. Registra	ar's Signature	J.				
				100				-		

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#23aperMD, 11/9/09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 pm 2009 October 28, Irena Stawnychy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Country Ukraine Months Hours 1072771927 Director 064-26-9269 82 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Silver Spring 1 Tes 2 X No Maryland Montgomery 10e. Street and Number 10g, Citizen of What Country? Funeral 1121 Cresthaven Drive 20903 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced White. Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) t of Health and Mental Hygiene. If item 27 is marked other tha Cytology Supervisor U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lubov Husar Petro Petryk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Cresthaven Drive, Silver Spring, MD Mykola Stawnychy-Husband Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If its any injury or ot ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10/31/2009 | Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lice see 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Instant Immediate Cause (Final Pnysician/ Acute Cardiorespiratory Failure disease or condition resulting in death) Medical Due Coronary Artery Disease Examiner 5 years Advanced Severé Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Coronary Artery Disease Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Chronic Hypertensive Heart Disease IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No

9 Unknown Month Pregnant at time of death g Unknown detached P.O. To the Hospital or Attending Physician: The law requires unat within 24 hours after death.

To the Funeral Director. After this certificate has been signed to completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Dementia 1 Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' 2 🗌 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ٩ 1 Inpatient 2 TER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical t 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, uearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) D63232 A106 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

15225 Shady Grove Rd., Suite 208, Rockville, MD 20850

M.D.,

Patricia S. Gomez,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37046 Reg. No 2 U U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:25 P 2009 Silverman November William /Medical 4a. Facility Name (If not institution, give street and number)
Suburban Hospital 4c. County of Death 4b. City, Town, or Location of Death Bethesda Examiner Montgomery 7. Age (In yrs. last birthday) 93 Yrs. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Months Days Hours Min. 578-09-9480 1 X M 2 □ F Feb 10, Washington DC 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Director DC None Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20007 United States 4602 Kenmore Drive NW 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify \$ Specify: White 3 Widowed 4 Divorced Year or Dates: 1942-45 Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Tree Service and College (1-4or 5+) Elementary/Secondary (0-12) Locker Company <u>Business Owner</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked cary injury or other traumatic ew once. Isaac Silverman Rose Gold ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10701 Quarterstaff Road Columbia MD 21044 Robin Sturman -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Judean Memorial
Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean 11/3/2009 Olney, MD 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc.
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service License MO1163 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 😾 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 😾 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

death certificate be Box (o The law requires that the σ. Vital Records, Physiclan: CARLARY.

signed by the attending p be detached for use as t signed by director, page 2 should has certificate this Hospital or Attending Pl 24 hours after death. Funeral Director; After t After To the Hospital within 24 hours a To the Funeral L

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Wedenl Experience is ust be notified at

nd Mental Hygiene. marked other than

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Medical

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi MD 8600 Old Georgetown Road Bethesda MD 20814

of certifier

(Check only one)

29b. Signature and

32. Registrar's Signature pares. NOV 03 2009

DHMH 17 Rev 1/2001

Registrar

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my college, death

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Datte signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#31, see#32-11/3/09, EMW, MbCb Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 134 PM 28, October 2009 RUBY ANN SHORT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 🗜 Months Hours 5/25/32 Director 77 MD 217-28-8132 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examination and be notified at 1 X Yes 2 □ No Director MD Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5607 White Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 Yes, Give 2 XNo 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Private Accounting Co. <u>Accountant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental It I tem 27 is marked ott James Ernest Short Agnes Grace Bond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kelli Pierson - daughter 3611 Kimble Road, Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of ceinetery) crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of F Pages 1 Important: If It any injury or c 1 Burial 2 4 Donation 2 ☐ Cremation 3 ☐ Removal Zion Church Cem. 11/6/09 5 ☐ Other (Specify) Mt Laurel, MD 21. Signatur of Euneral Service Licen 22. Name and Address of Facility Snowden Funeral Home ene 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. on not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Box 68760 Physician/Medical as 1 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 0 ∐Yes 2⊿No 9 Unknown 9 Unknown signed by t I be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₫ 3 Probably 4 Unknown 1 🗌 Yes Completed peen 245. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a. Was an autopsy this certificate has 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 2 ER/Outpatient 3 □ DOA 1∏Yes 1 Inpatient Certification: To completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who

115 ate filed (Month, Day,

Year)

9

2009

completed cause of death (Item 23a) (Type, Print)

NOV 03

32. Regist ar's Signature

0

EN

License number

29d. Date signed (Month, Day, Year)

Reisterstown, Ness Center DRIVE

			For State Registrar	State of M		epartme <i>Certifica</i>			nd Mental Hy	giene Reg. No.	009	37048
H	Physici		Decedent's Name (First, Middle, Las Asya	st)	Shilma	n			2. Date of De	ath	2009	3. Time of Death 2:25 P M
	/Medio Examir		4a. Facility Name (If not institution, give Shady Grove Adven		,	Roc	kvill		Death		unty of Death	
	Funeral Director		5. Social Security Number 6. S 215-37-3527 1 Usual Residence of Decedent	ex	ge (In yrs. last birt	hday) If Und Month	der 1 Year ns Days		Hrs. 8. Date of Bir Min. (Month, Di 06/26/	th ay, <i>Year)</i> 1946	9. Birthi Cour Ukra	
	A Maryland Ba-f show tified at	ctor	10a. State	ry	10c. City, Town						1	0d. Inside City Limits 1 ∰Yes 2 ☐ No
< 1-	ath with the 23a or 28	Funeral Director	10e. Street and Number 20 Indian Hills C	ourt			Zip Code 20855			USA	of What Coul	ntry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Mydical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ∐Yes 2X If Yes, Give Year or Dates:	?]No :	1 □Yes	2 ™ No	Specify:	i? (Specify Yes or No uerto Rican, etc.)		Race - Americ Black, White, ecify: Wh	
Baltimore, Maryland 21215-0036	d within 72 h giene. er than "natu the Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 4	5.1)	Decedent's U (Give kind of life. DO NOT) diac T	work done use retired	during most of d)	working	Medic	f Business/In	dustry
/land	uld be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Mosha Royzman				į		Name (First, Middle Shamistys		name)	
e, Mar	1 and 2 sho Health and em 27 Is mi		19a. Informant's Name/Relationship (1) Alexsandr Krivits 20a. Method of Disposition	Kiy Son-i		01 Cas	hell 1	Manor (or Rural Route Numb Court Der	wood,		355
timor	it. Pages rtment of rtant: If it njury or o		1⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Parkla	wn Mem	. Par	k 10	/28/2009	Rockvi	ille, N	Maryland
Ba	perm Depa Impo any l		21. Signature of Funeral Service Lines. 23a. Part1. Enter the disease, or compared to the com	plications that source	NO1163						lerar r	irection,
	Physician /Medical		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	sne cause on each l	line.		loae or ayıı	ig, such as ca	rulac of respiratory a	inest,	269	Interval Between Onset and Death
	certificate be executed contificate be executed conding physician and contient and contient and contient contie	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	openia s a consequence o der Canc s a consequence o	er					5	Years
P.O. Box 6	certii Iding Se a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 ☐ Ectopi 5 ☐ Other		у		23d.	Date of deliving Month	ery Day Year
rds, P.	es tha igned be de	þ	Part II. Other significant conditions co	ontributing to death	but not resulting in	the underlying	g cause giv	en in Part I.				he cause of death?
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i Vit	Physician: this certific al director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🛱 Inpat	ient 2 ☐ ER/Out	patient 3	DOA Oth	or:	Death (Check only only only only only only only only		Other (Specia	
Division of	ding h. After funer	Certification: To	27. Manner of Death 1 🖾 Natural 2 🗀 Accident 3 🗀 Suicide 2 Could not be		jury 28b. Ti	ijury M	<u> </u>	yat k? Yes 2 □ No	28d. Describe			al Route Number,
\equiv	P Pige	l Certif	4 ☐ Homicide determined 29a. Certifier 1₺ Certifying Ph	building, e	tc. (Specify)				City or Tò	wn, State)		,
D	To the Hospital within 24 hours a To the Funeral completely filled	ledical	(Check only 2 Medical Examone)		of examination and	d/or investigat	ion, in my c	pinion, death	place, and due to the occurred at the time,	date and pla	ce, and due t	o the cause(s)
b	2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Σ	29b. Signature and title of certifier	1]	29c. Licens D5901			Octobe	er 26,	
			30. Name and address of person who constantin A. Khl				Grov	e Road,	, #140 Ro	ckvil1	e, MD	20850
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 200	32 Regist	rar's Signature	pares	ò					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Sylvan Sherman October 0 30 2009 13:54 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospita1 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 074-14-4299 Director 88 March 31, 1921 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Exeminer must be notified at XXYes 2 □ No Director MD Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ with 5555 Friendship Blvd 23a 20815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1★1Yes 2□No WW11 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify: by by Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "ne any injury or other traumatic ewant. Elementary/Secondary (0-12) College (1-4or 5+) 5<u>+</u> Patent Attorney Intellectual Property 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Sherman Sadie Grundt ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5115 Manning Drive, Bethesda, Maryland 20814 f Disposition (Name of Date 20c. Location - City or Town, State Tracy S. Yaffe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3X Removal from State Golda 11/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Huntington Sation, NY ^{22. Name and Address of Fapen}zansky-Goldberg Memorial Chapel 1170 Rockville Pike Rockville, Maryland 20852 21. Signature of Funeral Strvice Licensee Edward Sage1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ᅙ ng physician and as the burial-transit Exami Alzheimers Due to (or as a consequence of): Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a the detached for ☐Yes 2 ☐ No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🖾 No After this certificate 1 ☐ Yes 2 🖾 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1∐ Yes 2√√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) √Sudavshan Siva, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) State NOV 03 Registrar

Sherman, Sulvan

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Month 01-2009 2: 10 AM Doris Birch Savage 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Coastal Hospice at Salisbury Wicomico the Loka If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🛣 F 213-24-2046 **Director** 80 12/8/1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be nutified at Director 1 TYes 2 NO No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12630 Old Bridge Road 21842 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: <u>۾</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 th and Mental Hygi Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Curtis H. Birch Esther Tubbs traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Victor Birch 12217 Sinepuxent Road, Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 11/4/2009 Berlin, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility The Burbage Funeral Home 108 William Street, Berlin, MD 23a. Part 1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co-sequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings evailable prior to completion of cause of death?

1 □ Yes 2 ☑ No his certificate has director, page 2 s autopsy performed? 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎢 No After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 X Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-01-2009 D29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA3 GREGORIO M. BELLOSO, M.D.; 5 302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 03 2009 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland /		ment of F ficate of t		nd Me			2009	37051
	Physici	an	1. Decedent's Name (First, Middle, L John William S		~_					Date of De Month Novemb	ath		3. Time of Death 5:45 P M
47.84	/Medic Examir		4a. Facility Name (If not institution, g		•	41:	o. City, Town, o	r Location of D		vovanu		. County of Dea	
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	Funeral Director		515-20-9427	Sex 7, Agr 1 M 2 □ F	e (In yrs. last t		Onths Days	If Under 24 Hours		Date of Bir (Month, Da Teb 11	th ay, Yea <i>r)</i>		thplace (State or Foreign buntry) ISAS
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locati	on	<u> </u>					10d. Inside City Limits
	e Mary la-f sh	ctor	CA Lake		Clearl	.ake							1 □Yes 2 No
	vith th	Director	10e. Street and Number				10f. Zip Code		-		10g. Ci	tizen of What Co	untry?
	eath v	Funeral	5575 Old Highway	53 Space 12. Was Decedent I		13 Was	95422 Decedent of H	ispanic Origin	2 (Specif		USA	14. Race - Ame	rican Indian
36	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Evanirer number for notified at	y Fur	1 ☐ Never Married 2 ☐ Married 3 🎞 Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N	io	If Ye	s, specify Cuba Yes 2 No	Specify:	uerto Ric	an, etc.)		Black, White	e, etc.
9-0	2 hour	ted	15. Decedent's	Year or Dates:		a. Decedent	's Usual Occup	ation			16b. K	ind of Business	
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/an	be d d	To Be	William Beldon S	•				Anna (
Maryland	S ar		19a. Informant's Name/Relationship		i i	_						or Town, State,	Zip Code)
	1 and 2 Health em 27 I		John William Sco	otton, Jr./s		of Disposition	oring Wa	ater Pa	ath J		<u> </u>	0 20794 ocation - City or	Town State
altimore,	Pages nent of nt: If it ny or o		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemei	tery, cremato	ry or other place ney Crei					odbine,	,
Balti	permit. Pages 1 Department of H Important: If ite any injury or of		21. Signature of Funeral Service Lic		MO1251	GÔ Î		*CRellat	tion	Servi	ce	P. O. E	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death. Do								Approximate Interval Between
	Physician	W. J	Immediate Cause (Final disease or condition resulting in death)	_a Arterios		ic Car	diovas	cular I	Disea	se			Onset and Death over 1 year
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):							
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X Q Q	atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal dea		topic pregnanc	у				23d. Date of de Month	ivery Day Year
o.	the de	ysic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ∐ Ot	her (specify) _						
Դ.	w requires that the de s been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death bu	t not resulting	in the under	lying cause give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
Records,	requir		Senile Dementia						_	1 🗆 '	Yes 2	□ No 3□ P	obabły 4XI Unknown
ě	ding Physician: The law h. h. After this certificate has b. funeral director, page 2 sl	ompleted			*					24a. Was autor perfo		prior to	topsy findings available completion of cause of
VITal	lan: T	Be Co	25. Was case referred to medical					26. Place of	Death (C			1 ☐Yes	2 No
OI <	Physician: this certific ral director, I	To E	examiner? 1 ☐ Yes 2 💆 No		nt 2 ER/C			4 LX INUISII	ng Home	5 ☐ Resi	dence	6 ☐Other (Spe	cify)
	ding F h. After funera	tion:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day		Time of Injury	28c. Injur Work	yat ⟨? Yes 2 □ No		I. Describe I	how inju	ry occurred	
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	e Hospita 124 hours e Funeral letely fille	Medical C	29a. Certifier 1X CertifyIng F (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner sta	examination a	ge, death oc and/or invest	curred at the tir igation, in my o	ne, date and p pinion, death	place, and occurred	d due to the at the time,	cause(s	s) and manner a d place, and due	s stated. to the cause(s)
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DHMH 17 Rev 1/2001

			for State Registrar		State o	of Mar	ylanc		irtment <i>tificate</i>			and M	lental Hy	giene Rea. No	200	9	370	052
	Physicia	ın/	1. Decedent's Name	(First, Middle, La	st)								2. Date of De			/ear	3. Time of	
	Medic Examin	al	Charles M 4a. Facility Name (if r			nber)			4b. City, T	rown, or	Location	of Death	11	2	. County of	009 Death	5:30	P ^M
J			Gilchrist						Tows	on				В	altimo			
	Funeral Director		5. Social Security Nu 217–24–25		Sex Mg 12☐F	7. Age (I	n yrs. las 80	t birthday) · Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of Bit (Month, Da 5/16/	ay, Year)	9	9. Birthp Count	ilace (State of try) PA	r Foreign
	ind show at	5	Usual Residence of I 10a. State	Decedent 10b. County		1	0c. City,	Town or Loc	ation							11	0d. Inside Cit	ty Limits
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	eath w tems? er mus	Funeral Director	3626 McAl 11. Marital Status	pine Rd.	12. Was Dece		er in U.S.	13. W	2104 /as Decede	ent of His	spanic O	rigin? (Spe	cify Yes or No	USA	14. Race -	America	an Indian,	
36	after d al", or i xamin	b	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed For 1 X Yes If Yes, Given	2 □ No ⁄e		9- 1	Yes, specif				Rican, etc.)		Black, Specify: V	White, e √hit.		
2-0	hours natura dical E	olete		15. Decedent's			1953	3 16a. Decede	ent's Usual	Occupa	ation			16b. K	ind of Busi			
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The fleath and Mental Hygiene. The mast is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	Completed	Elementary/Seco		College (1				ind of work NOT use i CC		uring mo	st of workii	ng	Ele	ectror	nics		
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	nysician/ Medical Examiner		disease or condition resulting in death)		a. Due to	(or as a	Seque	nce of):	, 1	Ra.	~	tai	lure			+	420	
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	cate be executed physician and sthe burial-transit	cal E	resulting in death) Li	ast	Due to	(or as a c	onseque	nce of):										
2/00	incate I ig phys as the	Medical	IE EENALE.		d											\perp		
20 X 02	ath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m	onths?	23c. If yes, out	Birth 2	Fetal (death 3 🗌	Ectopic pr		/				23d. Date of		,	/ear
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6	ng Pny fter this ineral d		27. Manner of Death	5 Pending	28a. Date		2	R/Outpatient 8b. Time of injury		c. Injury work?	at		me 5 Resi			Specify)	GICE	rist
VISION OF	Attending to death cotor: A sy the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not Indetermined	ne —	of Injury	- At hom	ne, farm, stree	M et, factory,	1 🗆 \	Yes 2□	_	28f. Location (Street and	d Number o	or Rural i	Route Numb	er
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:	The Hospital or Attending Physician: The law requires that the death certification but after death. To the Funeral Director: After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 12 (Check 2 only one) 3	✓ Certifying PhyMedical ExamCertifying Nu	sician: To the b iner: On the bas se Practioner:	sis of exan	nination a	and/or investig	gation, in m	y opinior	n, death c	ccurred at	the time, date a	and place	and due to	the cau	se(s) and mar	nner stated.
	Nithii Comp		29b. Signature in ti		0				29c.	License	number				te signed (A			
	الأص		30. Name and address	ss of person who	completed caus	se of deat	h (Item 2	3a) (Tvpe. Pr		16	81C	7		1)	13/0	H		
_			Eric Bi	ushmi	, 670	IN.	Ch	arles		Su	infe	410	5,6	alt	mor	70 M	M) 216	204
	Stat Registra		31. Date filed (Month	OV 0'4 2	009 22	egistrar's	Signatur	. Spa	Med				1			(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08457 State of Maryland / Department of Health and Mental Hygiene Stephen Snyder 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 1, 2009 0122 hrs **Medical Examiner** Stephen Snyder 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Director 172-58-0746 1964 Pennsylvania 45 Oct. 11, 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Charlestown 1 X Yes 2 No Cecil Maryland 28a-f show imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21914 U.S.A. 308 Market Street, Apt. No. 304 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes White Specify: 1 Yes 2 Y No specify: Widowed Divorced Yes Give Yeer ۾ 16b. Kind of Business/Industry Barnes & Noble Cecil College 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Four Years North East, Maryland 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Lindeman Robert L. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 134, Charlestown, Maryland Andrew J. Davis, III Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, permit. Pages 1 a
Department of He
Important: If ite West Chester crematory or other place) Burial 2 Cremation 3 Removal from State R.A.Ferris & Co.,Inc. 11/04/09 Pennsvlvania Donation 5 Other Specify. 21. Signature of Funeral Service Licens Name and Address of Facility & Son Funeral Home, Maryland 21903-0766 OVVE Perryville. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Occlusive Pulmonary Thromboembolism Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transit that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Dav 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 Vunknown ò مَ Diabetes Mellitus The law requires Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? 1 🗸 Yes ✓ Yes 2 certificate 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: Residence 6 Other: DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No After t 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) To the Funeral I (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

1. March

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

OCME

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 1, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PII per ME 8898 12/2/09 TT
State of Maryland / Department of Health and Mental Hygiene 0 0 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Glen Stanton November 9, 2009 4:30 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 33482 Garrett Hwy. Garrett Accident 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 X M 2 □ F 63 Yrs. Maryland Director Oct. 8, 1946 215-44-8875 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and: I fleem 27 is anarked other than "hatural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Event in the Indiffed at ury or other traumatic event, I'm Medical Event in the Indiffed at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 TNO MD Accident Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33482 Garrett Hwy. 21520 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 X Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Ş Q Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Finisher Building Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Hoover Edward Stanton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tronce. Judith K. Stanton/Wife 33482 Garrett Hwy., Accident, MD 21520 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crematory Nov. 10, 2009 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD ol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** per nucle Su /Medical Due to of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): CERTIFICATIO Box 68760, certificate has been signed by the ettending physician rector, pege 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ Anxie 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown Completed terminal aspiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 ☐ Yes 2 NO Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) Hospital: 1XYes -2 Who 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To Division of funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

leral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ò within 24 hours a

To the Funeral I

completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61801 e and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. Fourth St., Oakland, MD Kenneth Buczynski,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV12

32

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37055 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician October Sammy Jean Schnetzler 29, 2009 1328 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖼 F Director 510-24-6280 79 1930 Jul 28, Kansas Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Madical Exeminer must be notified at Director Westminster 1 ☐Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or a main july or other traumatic event, the theoriest Exmiter must be none. 21157 Funeral I 505 High Acre Drive, apt 15 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white ģ 1 ☐Yes 2 No Specify: 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bess Irvin Samuel Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3415 View Ridge Circle, Manchester, MD 21102 Ann Ackerman, daughter 20b. Place of Disposition (Name of Scannatery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2009 Winfield, MD Carroll Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a s a consequence of) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐Yes 2 🗖 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Chrenu-Pain 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination approximation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifier Medical (Check only one) nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address of person who complete

Abereuler

31. Date filed (Month, Day, Year)

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32. Registrars

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Registrar

cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 37056 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Nov 11, **Physician** Twigg 5:03pm [™] Millard Wayne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14702 Uhl Highway Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 12, 1945 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F Yrs. 214-46-3130 64 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evantment by Anti-Appendix 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 □ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 14702 Uhl Highway USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xio Specify: Specify: ģ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Management Central Intelligence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Millard David Twigg Pauline Twigg ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14702 Uhl Highway Cumberland MD 19a. Informant's Name/Relationship (Type. Print) MD 21502 Nancy Twigg sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State **Davis Memorial Cemetery** 11/14/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Carpelli Funeral Home, PA 21. Signature of Funeral Service L 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, of suck, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause or each line. d ease or condition resulting in deat **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pt for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t rector, page 2 s autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🗹 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No After this Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending rieral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M

DHMH 17 Rev 1/2001

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Mr

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorothy Lucille THOMSON 8, 200 9 November 10:50aM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Somerford Place Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 17,1924 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours 405-34-7391 85 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10114 Sharpsburg Pike 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 □ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) meat wrapper grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cam Fee Lola Stephens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Peters - daughter 213 Lake Street, South Kinkland, Washington 98033 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 12,2009 Flat Rock, Michigan 4 ☐ Donation 5 ☐ Other (Specify) Michigan Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 1 solul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death KENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy

1 □ Yes

5 Residence

26. Place of Death (Check only one

Other: 4 \sum Nursing Home

1 ☐Yes 2 ☐ No

28c. Injury at Work?

2

28d. Describe how injury occurred

assisTE

6 Other (Specify) L

Physician /Medical Examiner

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is activated Evancian in its be notified any pines.

Baltimore, Maryland 21215-0036

/Medical Examiner

Director

Completed by Funeral

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10a. State

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3	8

25. Was case referred to medical examiner?

1 ☐ Yes

27 Manner of Death

Natural

2 Accident

3 ☐ Suicide

2

5 Pending

investigation

1 🔲 Inpatient

Date of Injury (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the attending physician To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely

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STY	15	
	St	

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certified 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENNSYL UANIA AVE HACEKSTOWN MD 0 32. Retistrar's Signature Registrar

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Thomas Layman Thompson

2009 37058

		1- For State Certificate	of Death	Reg	g. No.						
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death									
ledical Examir		Thomas Layman Thompson		November	6, 2009 1420 nrs						
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Death						
. "		24898 Old Three Notch Road	Hollywood		St. Mary's						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	T Min	(MM/DD/YYYY) 9. Birthplace (State or Foreign						
Director		214-48-8312 1XM 2 F 54	rs. Months Days Hours	08/20/	1955 Country) Maryland						
	- [Usual Residence of Decedent									
v any	- 1	10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits						
and shov	ᡖ	MD St. Mary's Hollywo	od		1 Yes 2 No						
Maryland r 28a-f show	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?						
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shoundite event, the Medical Ex uniner must be notified at once	盲	24898 Old Three Notch Road	20636		United States						
with us 23	Funeral		Was Decedent of Hispanic Origin		14. Race - American Indian, Black,						
feath r iter	۳	1 Never Married 2 Married Armed Forces?	f Yes, specify Cuban, Mexican, I	Puerto Rican, etc.)	White, etc.						
after (by F	3 Widowed 4 Divorced If Yes, Give Year or Date:	Yes 2 X No specify:		Specify: White						
hours afte 'natural'', Ex miner			dent's Usual Occupation (Give ki		16b. Kind of Business/Industry						
72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT u	se retired)							
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than '	E	l Repa	ir Technician		Telecommunications						
5-0 led w Hygid othe		17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, M	· ·						
be fi	Be	Lamen Samuel Thompson	Alma	Teresa A	lvey						
22) A 21) A	ို		- ,		per, City or Town, State, Zip Code)						
MD d 2 sho dth and n 27 is			7 Maple Drive,								
			oosition (Name of cemetery, other place)	Date	20c. Location - City or Town, State						
Baltimore, permit. Pages I an Department of Hee Important: If iten mjury or other tr		T Dunai 2 2 Cremator 3 Nemoval non State	' '	11/10/2009	Charlotte Hall, MD						
mit.	- 1			Brinsfield	Funeral Home, P.A.						
E P P E		Laward N. Brinsfield, Jr. M00052 2	2955 Hollywood	Road, Leona	ardtown, MD 20650						
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	er the mode of dying, such as ca	rdiac or respiratory arre							
/Medical	- 01	failure. List only one cause on each line. Immediate Cause (Final disease a. Atheroscleotic card	diovaccular die	20250	Between Onset and Death						
*xaminer	- 1	or condition resulting in death) Due to (or as a consequence of):	ilovasculai uls	case							
	-	Sequentially list conditions, b.									
	ē	if any, leading to immediate Due to (or as a consequence of):									
	amine	(Disease or injury that initiated									
d ansit	ŭ	events resulting in death) Last Due to (or as a consequence of): d.									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	VUNDENDED									
50, te be	e e	IF FEMALE: 23a, PII, 2/, pe	ermE, g897 11/1	.9/09 TT	23d. Date of delivery						
8760, tificate be ng physic as the burn	튑	23b. Was decedent pregnant in the	Fetal death 3 Ectopic	pregnancy	Month Day Year						
x 6 th cer truse	흥	4 Pregnant at time of death 5	Other (Specify)								
Box e death c the atten	Physicia	1 Yes 2 No 9 Unknown 9 Unknown			1						
rds, P.O. Box 6 requires that the death cer been signed by the attendinould be detached for use.	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Par		bacco use contribute to the cause of death?						
ires t	힣	Ketoacidosis	<u>-</u>	1 Yes	2 V No 3 Probably 4 Unknown						
ords,	Completed			24a. Was a autops							
Reco The law icate has	E			perform	med? death?						
T. T. Tillifica		25. Was case referred to medical	26.Place of Death (Tes 2 No						
Vital Rec hysician: The this certificate	B	examiner? Hospital: 4 Innefinet 2 ED/Output	Othor		Residence 6 V Other: Scene						
of V ing Phy After th	의	Tes Z No			ow injury occurred						
ion of tending Pheat.	悥	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	1 Yes 2		• •						
Sicolar dea	g	2 Accident Investigation 28e Place of Injury - At home farm s	treet factory office building etc	28f Location (S	street and Number or Rural Route Number, City						
Division of Vital Records, rat or Attending Physician: The law requings after death. al Director: After this certificate has been sted in by the funeral director, page 2 should to	Certification:	Suicide Could not be determined (Specific)	troot, radiory, omeo bollaring, etc	or Town, St							
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	sourced at the time, date and pla	as and due to the source	c(c) and manner or stated						
the II	Medical	(Check only one) 1 Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or invest									
To with	Mec	29b. Signature and tittle of certifier	29c. License number		29d. Date signed (Month, Day, Year)						
	-	1///	O.C.M.E.		November 7, 2009						
			J.J.IVI.L.								
OSME		30. Name and address of person who completed cause of death (Item 23a)	111 Dann Street Balting	MD 21201							
			111 Penn Street, Baltimo	JIE, IVID Z 1ZU I							
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature	Ked								
DHMH 17 Rev 1/20	UT	ÖRIGI	NAL.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day ERLE EDGARD UKKELBERG OCT 2009 10:19 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL AT EASTON EASTON TALBOT 8. Date of Birth (Month, Day, Year) 6. Sex 1 AM 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours Min. 75 473-34-7177 OCT. 10, NORTH DAKOTA 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT STREET, APT. 240 21601 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Nes 2 ☐ No 1956— If Yes, Give Year or Dates: 1959 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES MANAGER INDUSTRIAL EQUIPMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDGARD WILLIAM UKKELBERG ELIZABETH PENILLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT UKKELBERG/SON 1330 MORLING AVE. BALTIMORE, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CENTER NOV. 1,2009 STEVENSVILLE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) xminutes Due to (or as a consequence of): ischemia Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last wonay 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tobacco 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

the death certificate be executed burial-tra P.O. Box 68760, attending physician for use as the buris signed by the all

Examine Physician/Medical Completed Be 2 Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò items 23a

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant.! firen Z1 is marked other than "natural", or ite muy or other traumatic event, The Madical Examinativy or other traumatic event, The Madical Examina

permit. Pages 1
Department of H
Important: If ite
any injury or ot
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Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death v

Director

Funeral

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Completed

Be

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completely filled in by the funeral director, To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After

State Registrar

Medical

25	Was case referred to medical examiner?
	1 Yes 2 No

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5	3	ey	m	ow	U/	u	0
		add occ					

29d. Date signed (Month, Day, Year)

e of death (Item 23a) (Type, Print) Physicians 508/dlewid Aunu, Earton, 15d

NOV 0 3 2009

			1 - State of N Registrar	laryland / Depa <i>Cel</i>	artment of F ctificate of I		•		09 37060
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death	
	Physici /Medic		Helen Elizabeth VanSant				0ct. 31	, 2009	1:25 P M
	Examin		4a. Facility Name (If not institution, give street and number 9708 Shady Grove Crt.	7)	4b. City, Town, or Ocean C	Location of Deat	4c. County of Death Worcester		
ı	Funeral Director		5. Social Security Number 6. Sex 7. A 1 ☐ M 2 ☐ F	ge (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		^h 2, 34). Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or Lo	cation				10d. Inside City Limits
ING 21215-0036 be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, it e Madical Exa. of armest be rectined at	Maryla -f sho	Director	MD Worcester	Ocean Cit					1√Yes 2□No
	th the		10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	
	by Funeral [9708 Shady Grove Crt.		2184			US		
		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Deceden Armed Forces 1 □ Yes 2 ② If Yes, Give Year or Dates	? \$ No	Nas Decedent of H fYes, specify Cuba I□Yes 2⊠No	Ispanic Origin? (San, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)		· American Indian, White, etc. White	
215-0036	72 ho 'natur	To Be Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o	during most of wo	rking I	16b. Kind of Busi	ness/Industry
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מסר	should be filed nd Mental Hygi marked other imatic event, I		17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Surname)	
Maryland			Arthur Canapp				rine Col		
Z Z	2 s l ar ls		19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street</i> 			er, City or Town, Si	tate, Zip Code)
e,	es 1 and of Health fitem 27 r other to		Arthur Nolen- son 20a. Method of Disposition	20b. Place of Dispo		-	Date 1710	20c. Location - C	ity or Town, State
Ē	Pages ment of ant; If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cape Hen]	open Cre	m	3, 09	Frankfor	d, DE
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		Name and Addre			uneral H MD 2181	
		3	23a. Part I Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not ent line.	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
1000	Physician /Medical		regulting in death)	ussent	Trough	nel cel	2 Carer	oma	9 years
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X Q Q	attend for use	eted by Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcom 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	
	t the de		1 Yes 2 No 9 Unknown	at time of death 3	TOther (specify) _				
<u>'</u>	es thai igned l		Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause give	en in Part I.			ute to the cause of death?
ecords,	requir								☐ Probably 4 ☐ Unknown
nec L	he law e has l	Completed					24a. Was autop perfo	psy pri rmed? de	ere autopsy findings available or to completion of cause of ath?
VITA	ian: T	0	25. Was case referred to medical			26. Place of De	1 □ Yes ath (Check only o		⊒Yes 2□No
o 	hysic this ce al direc	To B		ient 2 ☐ ER/Outpatien		4 L Nursing i	lome 5 Resid	dence 6 ☐ Other	(Specify)
	ding P	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, D) 28a. Date of In (Month, D)	jury 28b. Time of ay, Year) Injury	Worl	yat <br Yes 2 ⊟No	28d. Describe h	now injury occurred	I
DIVISION	Atten	ertification:	a D Could not be	njury - At home, farm, stre		Tes Z INO	28f. Location (S	Street and Number	or Rural Route Number,
5	ital or irs afte raf Dir led in	Cert	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manner s	of examination and/or in	n occurred at the tire vestigation, in my o	me, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, an	ner as stated. d due to the cause(s)
	Vithin To the comp	Me	29b. Signature and title of certifier	0	29c. Licens			29d. Date signed (
			· Pour ? Che	YW	4) 00	14314	-	nov. Os	2007
	BAO		30. Name and address of person who completed cause of PANPITP. KLU4. 10	CECON	Print)	T, Sol	es been	, ma	21801
	Star Registra		31. Date filed (Month, Day, Year) NOV 0 3 2009	trar's Signature					

NOV 0 3 2009 June B. Sparke

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 31, 2009 Physician 6:05 A M Jean Weissman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 17, 1909 New York 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 □ F Months Days 577-38-1776 100 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'm Madical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8100 Connecticut Ave., #1123 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ₫ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Armed Forces Institute Elementary/Secondary (0-12) College (1-4or 5+) of Pathology Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Klatzkin Benjamin Krueger ဂ္ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code, 324 Flannery Lane, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print) Marshall Weissman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 11/03/09 Olney, MD TOPENTUSKY SHEBYEW Funeral Home M01008 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ∢Physicían Abdominal Aortic Aneurysm (Leaking) Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas l autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 | Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 1, 2009 2 D 32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh K. Gupta, M.D., 9801 Georgia Ave., Suite 220, Silver Spring, MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature State NOV 03 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month October Physician/ 27 200^{Teal} 9:34 <u>Lillian Weiss</u> p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🛣 F Months Hours 0/01/192 Director 577-20-3523 88 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Marylanc Director ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 ☐ No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 14401 Traville Garden Circle #404 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) "unknown" t. Page 1 and 2 should be filed with triment of Health and Mental Hygier rtant: If item 27 is marked other 1 njury or other traumatic event, th Owner Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Gindes Fannie Seigel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Spruce Tree Avenue, Bethesda, Maryland 20814 Natalie Simon, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3
☒ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) King David Meml Gdns 10/30/2009 Falls Church, Virginia Signature of Tuner I Sourice Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 1091 Rockville Pike, Rockville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ month disease or condition Gastric Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform certificate 2 🗌 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 X No 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

completed filled in by the funeral director, To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t

State

10

29a, Certifier

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. Nelson Kalil, 5454 Wisconsin Avenue, #1300, Chevy Chase, Maryland Registrar's Sig arke 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

October 29, 2009

29c. License number

5

6/6

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08645 State of Maryland / Department of Health and Mental Hygiene Michael Walsh 2009 37063 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 6, 2009 1918 hrs Michael E. Walsh Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 215-76-1358 Many land Director 51 May13,1958 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 0c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Columbia Maryland Howard 23a or 28a-f show notified at once Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21046 United States 8425 Blue Stone Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married Never Married Yes If Yes, Give Year Yes 2 X No specify: Specify: White 3 Widowed Divorced "natural", ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 If item 27 is marked other than or other traumatic event, the Medical Nichols Power System Electrician 1 - 418.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorraine Stanekenas James N. Walsh (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 8425 Blue Stone Court Columbia, Maryland 21046 Karin L. Walsh -wife 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 11/11/2009 SilverSpring, Maryland Important: I injury or oth Donation 5 Other Specify 21. Signature of Funeral Service Licensee ²Domand Agress Borgwardt Funeral Home, PA Donald V. Ba 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Acute myocarditis complicating chemotheraphy for Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): colon adenocarcinoma Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last tending physician and use as the burial - transit hysician/Medical X UNPENDED AMENDED 23a,PII 27, permE, 2898 12/4/09 TT the Hospital or Attending Physician: The law requires that the death certificate bean 124 hours after death. Box 68760, 23d Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c, if yes, outcome of pregnancy Dav Year 3 Ectopic pregnancy Month Live birth Fetal death the attending past 12 months? Pregnant at time of death Other (Specify) 5 detached for 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 屲 Yes 2 V No 3 Probably 4 ò Cardiomegaly with myocardial scarring and coronary Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an director, page 2 should prior to completion of cause of artery tunneling autopsy has death? performed? 2 No 1 🗸 Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 Inpatient After this 1 Yes funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1X Natural Yes 2 after death.

Director: /
d in by the fu Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Funeral I determined (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME

To the

Deputy Chief Medical Examiner Mary G. Ripple MD. 31. Date filed (Mon N OV

30. Name and address

29b. Signature and title of certifier

32. Registrar's Signature Buena

and manner stated

of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 8, 2009

State

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

82. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 4, 2009

Physician /Medical Examiner

Physician

Examiner

10a State

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

attending physician and for use as the burial-tra certificate has t irector, page 2 s after death Director:

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3 Ector	oic pregnancy r (specify)		23d. Date of deli Month	ivery Day Year	
Part II. Other significant condition	ns contributing to death but	not resulting in the underlying	ng cause given in Part I.		co use contribute to	the cause of death?	
				24a. Was an autopsy perform of 1 □ Yes 2	prior to death?	topsy findings available completion of cause of	
25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatient 3	Othor	ath <i>(Check</i> on <i>ly</i> one) Home 5 ☐ Residence	e 6 ☐ Other (Spec	cify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, ation	28b. Time of	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred		
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine		y - At home, farm, street, fac (Specify)	ctory, office	28f. Location (Street City or Town, St	eet and Number or Rural Route Number, State)		
29a. Certifier 12 Certifying (Check only one) 2 Medical E	g Physician: To the best of examiner: On the basis of eand manner state	examination and/or investiga	rred at the time, date and place ation, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)	
29b. Signature and title of certifier	laryoro.	20 80.	29c. License number	44 12	Date signed (Month	h, Day, Year)	

State Registrar

31. Date filed (Month, Day, Year) NOV 13

30. Name and address of person who completed cau

- Hospital

32. Registrar's Signature

5401 Old Cowert

se of death (Item 23a) (Type, Print)

בא 24 hours aft ie Funeral Di etely filled in within 24 hor To the Fune completely f

Randallstown MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 3**7**067 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Patricia Thurber Zebal November 2009 1:40a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carrol1 Fairhaven Health Center Svkesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕅 F Months Days Hours 571-10-5920 90 IL Sept 27 1919 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Sykesville Carrol1 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7200 Third Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □X0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) public relations Elementary/Secondary (0-12) College (1-4or 5+) public relations administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Denison Thurber Ruth Agnew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $115\,$ Smith Ave., Westminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Bradley Zebal (son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State All County Cremation | 11-2-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final anorexia. disease or condition resulting in death) Due to (or as a consequence of) dysphasia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a55 cess Due to (or as a consequence of): Cancer If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed

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After

n 24 hours after death.

Ne Funeral Director: Af olderely filled in by the fun

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Records, P.O. Box 68760.

Division of Vital Hospital or Attending Physician:

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun once.

Physician

/Medical

Examiner

Director

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Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantural paratified at

death with the

72 hours after

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12 should be filed with and Mental Hygier 7 Is marked other the

Baltimore, Maryland 21215-0036

burial-transi physician at the burial attending pl signed by the a d be detached for

Examiner page 2 s director

Physician/Medical

Completed မှ Certification:

Medical

completely State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Road Eldersburg MD 21784 1645 LISGA

29c. License number

31. Date filed (Month, Day,

29b. Signature and title of certif

(Check only one)

32. ₽€gistrar's Signature THE MARK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year ROSEALIE M BASE ovember 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death mare Hosp 740se Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2√2 F 84 214-20-8591 Yrs 9-1-1925 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State BALTIMORE MD PARKVILLE 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 ROCK CREEK COURT APT 2A 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) CAREFIRST ADMINISTRATIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JOSEPH** W. BASE MARY F. UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSEDALE, MD RICHARD PAZOUREK/COUSIN 4934 BRIGHTLEAF CT 21237 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO 11-19-09 CREMATORY CATONSVILLE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE. 21237 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Monay Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of): ementio ue to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ongestive 1 ☐Yes 2 No 25. Was case referred to medical examine? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

18

2009

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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event, the Medical Examiner must be notified at

"natural", or Items 23a or

1 and 2 should be filed within 72 hours after t Health and Mental Hygiene. em 27 Is marked other than "natural", or Itel

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked 1 any lightly or other tranmatic events.

Maryland 21215-0036

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/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician signed by After this n 24 hours after death.

The Funeral Director: A pletely filled in by the fi

Division of Vital Records, P.O. Box 68760,

Physician/Medical <u></u> Completed Be Certification: To

Examiner

cal

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie,

Jigar

31. Date filed (Month, Day,

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

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Year)

1 Inpatient

and manner stated.

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Degistrar's Signatu

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Date of Injury (Month, Day, Year)

State Registrar

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2 ER/Outpatient 3 DOA

28c. Injury at Work?

16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

D69540

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 A M James Arthur Bunke 2009 /Medical November 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa 611 Academy Rd Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **X**XM 2∏ F 220-14-9972 Director 85 May 7, 1924 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Fedical Evention must be notified at Baltimore Maryland Catonsville 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Frederick Villa 611 Academy Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🌠 No Specify: Spe White þ 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer 12 Tool and Die Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Bunke ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaClaire Bunke Sister 2601 Madison Ave, #1108 Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2009 Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 21. Signature of Funer | Service License i 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami the burial-tran ue to (or as a conseque to Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for (in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 attending physician the Records, certificate Division of Vital

altimore, Maryland 21215-0036

the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica mpletely filled in by the funeral director, p

Certification: To

Medical

29a. Certifier

(Check only

State Registrar 29b. Signature and title of certifier

29c. License number D21649

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) November 13, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

"Wilkens Art Baltimore, MD 2 (229

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physici<u>an</u> 6:22 P M Nevember 15 2009 BERNHEIM, JR. BERTRAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROLAND PARK PLACE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-14-1914 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min 1**X** M 2□ F 95 MD Director 219-01-9686 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or edical Examiner must be 830 W. 40TH STREET, 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) STOCK BROKER INVESTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. Be BERTRAM M. BERNHEIM HILDA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS B. HESS/NEPHEW 13 ROLAND MEWS, BALTIMORE, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 11-18-2009 | BALTIMORE, MD DRUID RIDGE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arkrisselvokie carolinascular Tears **Physician** /Medical Due to (or as a consequence of): Examiner Hugerschaue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy perform certificate | 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dr. Balelee Mac the gar or D Nevember 16, 2009 013657

State Registrar

31. Date filed (Month, Day, Year) NOV 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TINBELLE TACTURE, 570 21211 32. Fegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 12, 2009 **Physician** Vincent Coleman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Montgomery Co. Olney 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 → M 2 → F **Funeral** 578-96-3525 43 3-14-1966 Washington, **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be realised at Directo Md. P.G. Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4004 Vine Street 20743 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No 21215-0036 Specify: 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disable Disable th and Mental Hygie 7 is marked other ti Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Coleman Albert Lucille Holmes ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 4004 Vine Street, Capitol Heights, Md. 20743 Verleece Epperson - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition jo ortant: If i 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Riverdale Pk Crematory 11-18-09 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Licensee 10583 Middleport Lane, White Plains, Md. 20695 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Carrier Hores /Medical Due to (or as a consequence of): Examiner Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed thin 24 hours a

Be

Certification: To

Medical

State

Medical Direct 1050410

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 11/13/09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4:01 pm

1 Yes 2 □ No

M.a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

18101 Prince Philip Dr Cheg 20832

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

(Check only

29a. Certifier

32. Registrar's Signature

Registrar

			1 - For State Registrar	State of Marylan	nd / Department of h		Mental Hygier	ne 2.009	37072								
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last, 1650 M 4a. Facility Name (If not institution, give	larshall	COOK 4b. City, Town, o	r Location of Death	DODOWAG	Day Year L 15 2007 4c. County of Death	3. Time of Death								
	Funeral Director	*	517 Bloom Street 5. Social Security Number 6. Sec		Baltimo	re	8. Date of Birth (Month, Day, Ye 8-30-192		place (State or Foreign intry)								
	ie Maryland Be-1 show	ector	Usual Residence of Decedent 10a. State 10b. County MW Ball-wo	01	y, Town or Location altricor				10d. Inside City Limits 15 Yes 2 □ No								
	d within 72 hours after death with the Maryland liene. r than "neturel", or Itams 23e or 28e-1 show The Medical Exaria ner must be indiffied at	Funeral Director		12. Was Decedent Ever in U. Amed Forces?	S. 13. Was Decedent of Fif Yes, specify Cubi	lispanic Origin? (Si	pecify Yes or No-	Citizen of What Cou LS A 14. Race - Ameri Black, White,	ican Indian,								
21215-0036	C * 38	Completed by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade		1 ☐ Yes 2 ☒ No 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire)	during most of work	king 16b	Specify: Afri	ican-American Industry								
	be filed tal Hyg d othe event,	Be	Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Taylor Cook	College (1-4or 5+)	Maintenance	18. Mother's Nam	ne (First, Middle, Maid	-	using Authority								
e,	is 1 and 2 should be the alth and Menta item 27 is marked othar treumatic events.	-	-	To	19a. Informant's Name/Relationship (Ty Diane J. Young/Daughte	c	19b. Mailing Address (Street 612. Swan Creek F	Road, Ft.Was	ral Route Number, Cit shington, MD	20744							
	permit. Pages. Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R ☐ Donation 5 ☐ Other (Specify) 1. Signature of Funeral/Service License	Garr	Place of Disposition (Name of pemetery, crematory or other place in SON Forcest Veters 22. Name and Address	ns 11-2		Location - City or T INS Mills, me P.A. of	MD								
	Physician		23a. Party Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death re cause on each line.	h. Do not enter the mode of dyir		dallstown, M or respiratory arrest,	21133	Approximate Interval Between Onset and Death								
. Box 68760,	Medical Examiner Asician and be purial-transit	ical Examiner	cal	Cal	ical	ical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of): 2 VQS(LQ-)(Cuence of):	- acci	dont		7 years				
	that the death certifics ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 Ectopic pregnancy	,		23d. Date of deliv Month	very Day Year								
Records, P.	law requires that the as been signed by th 2 should be detache	Certification: To Be Completed by	Certification: To Be Completed by	Certification; To Be Completed by	To Be Completed by	To Be Completed by	To Be Completed by	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the underlying cause giv	en in Part I.		o use contribute to t	the cause of death?			
Vital Rec	The ate ha							To Be	To Be	e l	25. Was case referred to medical			26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 12 th (Check only one)	prior to co	opsy findings available ompletion of cause of
of	To the Hospital or Attanding Physician: white 24 hours after death. To the Funaral Director: After this certification the Funaral Director or the funeral director, and the funeral director director directors are directors.									27. Manner of Death 1 5 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Oth 28b. Time of Injury Wor M 1	er: 4 ☐ Nursing H	ome 5 Residence 28d. Describe how in		(y)	
-	pital or Atta urs after de aral Directo illed in by th				3 Suicide 6 Could not be determined	building, etc. (Specify			28f. Location (Street City or Town, St	ate)							
1	To the Hospital of within 24 hours as To the Funaral E completely filled it	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	wledge, death occurred at the tir tion and/or investigation, in my o	pinion, death occur e number	red at the time, date a	Date signed (Month.	Day, Year)								
,			30. Name and address of person who co		NOP MO 23a) (Type. Print) May 1000 Blud B	10510 192 K	Baltim	ONE 1	16,2009								
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 9 2009	3. Registrar's Signa	- parkel												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Collins larsha ovember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Se cours Himor HOSDI FOR City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 1 F Days Hours 7-8-1954 214-64-1193 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Modical Evandines must be notified at Director 1 XYes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 523 retreat Street 21217 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ specify: African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the M. do once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Analyst Social Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Collins ဂ္ Mary Lowery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Collins/Son 311 Furrow Street, Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 11-20-09 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Jure of Funeral Service License 22. Name and Address of Facility Wile Funeral Time P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 and a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician 5 minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dusto (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should has been Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐Yes 2 ☐No 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending F After 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29b. Signature-and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address GOURS State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Maxine Delvison 2009 2:41 November 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Hurbor Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Ye May 26 9 Birthplace (State or Foreign **Funeral** -02 1 □ M 2 🔀 F Months Days Hours Min. Director 36 NOrth Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 □ No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify. 9 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed. Department of health and Mental Hyp. Important: If tiem 27 is marked any injury or other the any injury or othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Print grain 19a. Informant's Name/Relationship (Type. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Condition 5 Other (Specify) 12009 ul 21. Signa ure of Fun-ral Service License Home WOFF. Avei Bay 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner perkaleny Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (br is a consequence of): law requires that the death certificate be executed Due to (of as a consequence of): and burial-trar Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) ned by the a P.O. 9 I Inknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Accident has autopsy performed? Yes 2 XNo certificate Bivision of Vital 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1XYes 2 □ No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar David

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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62. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scherage

9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day 2009 orne 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 60 Himore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 8. Date of Birth
(Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 193-22-8643 1 M 2 □ F 8 Pennsylvania **Director** Oct 11, 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Funeral Director altmor 10f. Zip Code MD 10e. Street and Number 10g. Citizen of What Country? Heath 2123 nted 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be les 1 and 2 should be fill of Health and Mental H ၉ orneliu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 62 James John Francis Driscol ast Heath street altimore MD 21230 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State rounsuille VA Cemetery Nov 20, 2019 Crownsuille, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremations ervices - Parkville 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville Manyland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 □ Yes 2 □ No 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2. No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐No hours after death uneral Director: filled in by the 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year

32. Registrar's Signature

047934

29d. Date signed (Month, Day, Year)

PAULPL BALTIMORE MO 21202

NOVEMBER 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 2009 Earl 8:33 AM Everett 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

Months

10f. Zip Code

1 ☐ Yes 2X No

16a. Decedent's Usual Occupation

Receptionist

7. Age (In yrs. last birthday)

66

Jones

10c. City, Town or Location

Baltimore

Baltimore

Days

21201

(Give kind of work done during most of working life. DO NOT use retired)

If Under 1 Year | If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Ella

Min.

N/A

U.S.A.

Davis

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

Sales Office

8. Date of Birth (Month, Day, Year) 0 7 / 2 2 / 1 9 4 3

18. Mother's Name (First, Middle, Maiden Surname)

Mae

Birthplace (State or Foreign Country)

Cárolina

10d. Inside City Limits 1 X Yes 2 ☐ No

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

Physician

Examiner

Funeral

Director

/Medical

Edna

10a. State

MD

10e. Street and Number

817 West

11. Marital Status

Ernest

Directo

Funeral

ģ

Be Completed

Genesis Homewood

10b. County

N/A

15. Decedent's Education (Specify only highest grade completed)

1 □ M 2 🔀 F

Saratoga Street Apt.1

College (1-4or 5+)

5. Social Security Number

240-68-0103

Usual Residence of Decedent

1 XNever Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12th Grade

Physician /Medical Examiner

Completed by Physician/Medical Examiner The law requires that the death certificate be execute signed by the attending physician and I be detached for use as the burial-tran peen certificate has be irector, page 2 sl the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

	Line David	
19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	
Adrienne Robbins (dau	ighter) 817 West Saratoga Street Apt.3., Ba	arto.,MD
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or 20c. Trinity Cemetery 11/20/09 Baltimore	
21. Signature of Funeral Service Licensee		
jacqueline 8. 1	Joseph H. Brown Jr. Funeral Hor 2140 N. Fulton Ave., Baltimore	me ,MD 21217
23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line.	Approximate Interval Between Onset and Death
resulting in death)	o (or as a consequence of):	
causé. Enter Underlying	o (or as a consequence of):	
that initiated events c.		
d.	o (or as a consequence of):	
in the past 12 months?	utcome of pregnancy birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy gnant at time of death 5 ☐ Other (specify)	ivery Day Year
Part II. Other significant conditions contributing to c	death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ Pro	
	24a. Was an 24b. Were au autopsy performed death?	topsy findings available completion of cause of
	1 ☐ Yes 2 ☑ No 1 ☐ Yes	2 A MO
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
Hospital:	Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Spec	nifu)
27. Mann of Death 28a. Date	(-)	any)
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,
(Check only 2 Medical Examiner: On the I	e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due oner stated.	s stated. to the cause(s)
29b. Sighature and title of certifier	29c. License number 29d. Date signed (<i>Month</i>	n, Day, Year)
30. Name and address of person who completed cau	8813 Waltham Woods Know MD	21234.
31. Date filed (Month, Day, Year) 32/F	Règistrar's Signature	1

DHMH 17 Rev 1/2001

State Registrar

Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

> State Registrar

29b. Signature and title of certifier

Francis X Carmody 7505 Osler Drive Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla S C Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rectified at
•		Examme
A	Division of Vital Records, P.O. Box 68760,	tal or Attending Physician: The law requires that the death certificate be executed is after death. In al Director: After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit

	1. Decedent's	Name (First, Middle,	Last)			rtificate of		2. Date of Death		Year 3.	Time of Dea
ian cal	JAM	ES H	H. FRA	ANK				NOVEMBE	R 14 2	2009	3:30
ner		me (If not institution,					or Location of Deat	h		y of Death	
	5. Social Secur	5 SAGRAM	ORE ROA	AD 7. Age (In yrs. I	last hirthday)	ROSE		. 8 Date of Birth		9. Birthplace	(State or Fo
	212 28		1 □k M 2 □ F	78	Yrs.	Months Days	Hours Min.		1931	MARYL	AND
Director	10a. State MD	10b. County BALTI	MORE	1	y, Town or Lo						nside City L □Yes 2
Dire	10e. Street and					10f. Zip Code		10	g. Citizen of	What Country?	
Funeral		SAGRAMO		edent Ever in U.S	S 13	212		Specify Yes or No-	USA 14 Ra	ice - American In	dian
þ		Married 2 ∑X Marrie ed 4□Divorced	Armed Fo	orces? 2 [3 No ive		If Yes, specify Cub 1 □ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)		ack, White, etc. WHT	
Completed		15. Decedent's Specify only highest	grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of E	Business/Industry	у
E O	Elementary/	Secondary (0-12)	College (1-4or 5+)	BUYE		,		CROWN	, CORK	& SE
Be C		ame (First, Middle, L	*		-			me (First, Middle, M	laiden Surna	me)	
75 E	DANIE	EL F. 1	FRANK				CATHE	RINE	ւ	SMITH	
		t's Name/Relationshi						ural Route Number			
		ANNE F	RANK /	WIFE			MORE RO	AD BALT			
		2 Cremation 3		State	emetery, cre	osition (Name of matory or other pla				- City or Town, S	
		ion 5 Other (27)		GAI		OF FAI				MORE, N	
	21. Signature	of Funeral Service Li	icensee					VACH/ROS			
ı	resulting in de	st conditions,	b	(or as a consequ	uence of):						
miner	cause. Enter l Cause (Diseas	Underlying se or injury	Due to	or as a conse	uence of:						
dical Examiner	cause. Enter	Underlying se or injury vents	c	or as a conse a							
Ea .	cause. Enter T Cause (Diseas that initiated eresulting in de IF FEMALE: 23b. Was decein the par	underlying se or injury vents ath) Last edent pregnant st 12 months? 2 □ No	c	(or as a consequence of pregna birth 2 □ Feta gnant at time of d	uence of): ancy	□ Ectopic pregnan	ісу			pate of delivery Month Day	Yea
by Physician/Medical	cause. Enter Cause (Diseas that initiated eresulting in de resulting in de resulting in de resulting in the part of the part o	underlying se or injury vents ath) Last edent pregnant st 12 months? 2 □ No	c	utcome of pregna birth 2 ☐ Fetal gnant at time of d	uence of): ancy I death 3 l death 5 l	Other (specify)		23e. Did tot 1 □ Ye	pacco use co		use of deat
Completed by Physician/Medical	cause. Enter Cause (Diseas that initiated eresulting in de resulting in de IF FEMALE: 23b. Was deccin the part II Other s	edent pregnant st 12 months? 2 No	c	utcome of pregna birth 2 ☐ Fetal gnant at time of d	uence of): ancy I death 3 l death 5 l	Other (specify)	iven in Part I.	1 ☐ Yes	nacco use cons 2 No	Month Day	use of deat 4 Unk findings ava
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e Completed by Physician/Medical	cause. Enter Cause (Diseas that initiated eresulting in de resulting in de res	edent pregnant st 12 months? 2 No No Death all 5 Pending investige e 6 Could no	C	utcome of pregna birth 2 Feta gnant at time of d nown death but not result inpatient 2 e of Injury nth, Day, Year)	uence of): ancy al death 3 leath 5 le	Other (specify)	26. Place of Deher: 4 \(\text{Nursing} \) Nursing	1 □ Ye 24a. Was ai autops perfor 1 □ Yes 2 ath (Check only on	nacco use cons 2 No	Intribute to the ca 3 Probably Were autopsy f prior to comple death? 1 Yes 2	use of deat 4 □ Unki findings ava tion of caus
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Be Completed by Physician/Medical	cause. Enter Cause (Diseas that initiated eresulting in de resulting in the part I	edent pregnant st 12 months? 2 No No Death shall 5 Pending shall 5 Pending shall 6 Certifying and Certifying shall 5 Medical 2 No Death shall 5 Medical E Medical E Medical E Medical E Medical E	C. Due to d. 23c. If yes, ou 1	utcome of pregna birth 2 Feta gnant at time of d nown linpatient 2 e of Injury at he ding, etc. (Specifice best of my knobasis of examina	uence of): ancy I death 3 death 5 dea	Other (specify) Int 3 DOA Of Int 3 DOA Of Int 3 DOA Int WC M 1 Creet, factory, office th occurred at the investigation, in my	26. Place of De her: 4 \(\text{Nursing} \) Ves 2 \(\text{No} \) No time, date and place	1 Ye 24a. Was an autops perform 1 Yes 24th (Check only on Home 5 Reside 28d. Describe home 28d. Describe home 28f. Location (St. City or Town coe, and due to the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the courred at the time, described by the control of the course of the cou	nacco use cons 2 No 24b nacco	Intribute to the ca 3 Probably Were autopsy for prior to comple death? 1 Yes 2 Inter (Specify) Inter or Rural Role manner as stated	use of deat 4 □ Unk findings ava tion of caus No ute Number d. cause(s)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Physician Margaret рМ Hill 13 2009 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Season's Hospice Windsor Mill Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. 09/26/1937 N. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min 244-64-6019 72 Carolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, ith Marical Expriner rest be notified at once. 10a. State 10h. County 10c City Town or Location 10d. Inside City Limits Completed by Funeral Director 1**V**Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 751 West Saratoga Apt.212 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 Cook Years Charlie Place 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rev. Charlie O. Hill ೭ Channie Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vida Hill (Daughter) 1033 Hollins Street Balto., MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 11/21/09 Baltimore, Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. D_j not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760% Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 🗓 🗓 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation To the none after deam.

Within 24 hours after deam.

To the Funeral Director After the funeral Director After the funeral Director After funeral Director After funeral Director After funeral Director 1 ☐ Yes 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Milli 11/14/29 Thursd DA7683 30. Name and addr 4s of person who completed cause of death (Item 23a) (Type, Print) 25 Man Mille 21136 Maymend SNar Swite Zas Reisostown 62. Registrar's Sign 31. Date filed (Month, Day, Year) ture State Registrar

Baltimore, Maryland 21215-0036

P.O. I

Division of Vital Records,

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician mmo 5:00 PM DV /Medical 4a Facility Name (If not institution, give stre 4b. City, Town, or Location of Death 213then 4c. County of Death Examiner Assisted althnone Tome 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdey) **Funeral** 9 Days 10 M 2□ F Hours 212-09-7770 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 Yes 2□No **Funeral Director** MOLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code O 12. Was Decedent Ever in U,S. Armed Forces? 14. Race -American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 X No ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: 2 Specify 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lan ith and Mentel Hygier
It is marked other the Doration d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumamb) Be tammo orman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rne 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition ŏ important: If It any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Toseph L. Ryss 12222 W. North KUSS Funeral Home Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima e Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PHEUMONIA 102 Examiner Due to (or as a consequence of) Examiner bunel-transit requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the Due to (or as a consequence of): cartificete has been signed by the attending iractor, pege 2 should be detached for use as Division of Vital Records, P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown MEWILA Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TITES 20010 1 ☐ Yes 2 No funeral diractor, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Ascisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) 2 No Certification: To 1 ☐ Yes 3□ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title/of certifier 29c. License number D0061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 DILVERS AVE # 307 BACT. MD 21229 QUAINOD WO BENEZER 3. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MOV 1 9 2009

		For State Registrar	State of Ma		artment of F ertificate of	Health and M <i>Death</i>		jiene _{leg. No} 2 0 0 9	37083
Physi	ician	Decedent's Name (First, Middle NANCY KING HO					2. Date of Dea Month November		3. Time of Death 4:30P M
/Med Exam	dical niner	4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death	Novaliber	4c. County of De	
Funera	al	210 East Lake Avenu	6. Sex 7. Age	(In yrs. last birthday			8. Date of Birth (Month, Day)ctober 3		Birthplace (State or Foreign Country) W YORK
Directo	or	224-42-6398 Usual Residence of Decedent	XX 80	Yrs.			october 3	1,1929 Ne	
/larylan f show	ō	10a. State 10b. County Maryland None		10c. City, Town or L Baltimore	ocation				10d. Inside City Limits Y Yes 2 □ No
th the Nor 28a-	Funeral Director	Maryland None 10e. Street and Number		Datchiore	10f. Zip Code	_	1	log. Citizen of What	100
s 23a o	eral	210 East Lake Aver	12. Was Decedent E	vor in IIS 13	21212		cify Ves or No-	USA 14 Bace - A	merican Indian,
15-UU36 72 hours after death with the Maryland "natural", or items 23a or 28a-f show dicel Examinat be notified at	þ	11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divorced	ried Armed Forces? 1 □Yes 2 N	0	If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)	Black, W	nite, etc.
Z15-UU36 hin 72 hours aft e. an "natural", or Medical En mi	Completed		st grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of workir d)	ng	16b. Kind of Busine	ss/Industry
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ed all be	To Be (17. Father's Name (First, Middle, Julius King	Last)			18. Mother's Name Rebecca		Maiden Surname)	
and man		19a. Informant's Name/Relations Kenneth S Munson	hip (Type. Print) Husba	1	-	and Number or Rura nue Baltimor			e, Zip Code)
Baltimore , Mi permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Notice 2 Cremation 4 Donation 5 Other 15	3 ☐ Removal from State	20b. Place of Disp cemetery, cre Dulaney Va	position (Name of ematory or other pla 11ey Mem Gar	rdens 11/20/0	pate 09	20c. Location - City Timonium,	Maryland
balti permit. Departi Importa any inju	ouce.	Donnes My	Men Ken	apels	6500	ess of Facility Mito York Road E	Baltimore	, Maryland 2	1212
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icate be executed physician and sthe burial-transit	I Examine	Sequentially list conditions, if a y, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
68 / 60 tificate be e g physiciar as the buria	ledical	in-	d						
COLGS, P.O. BOX by requires that the death certiff been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 decired at 1 ☐ Pregnant at 1 decired at 1	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of Month	delivery Day Year
HECOTAS, P.O. The law requires that the ate has been signed by the age 2 should be detache.	Þ	Part II. Other significant conditi	ons contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did to		e to the cause of death?
The lay ate has bage 2	Completed						24a. Was a autop perfor	sy prior rmed? deat	e autopsy findings available to completion of cause of n? /es 2 \sumbox No
VITAI sician: T certifical rector, pa	Be	25. Was case referred to medica examiner?	Haspitali		· all post Ott	26. Place of Death			
ding Physi h. After this c	n: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pendir	1 ☐ Inpatiel	nt 2 ER/Outpati y 28b. Time Year) Injury	ent 3 DOA	4 L Nursing Ho		dence 6 Other (5	Бреспу)
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DIVISION To the Hospital or Attention within 24 hours after deatl To the Funeral Director: completely filled in by the	edical Ce	(Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/or	investigation, in my	opinion, death occurr	red at the time,	date and place, and	due to the cause(s)
To the within ? To the comple	Med	29b. Signature and title of certifie	and mariner sta		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
		- W	0, MD)	Do	069324		NOU. (8,	2004
		MEI TANG	wno completed cause of de	Charles	St., Su	uite 205	, Balt	imore, L	1D 21204
S Regis	State strar	30. Name and address of person MEI TANG 31. Date filed (Month, Day, Year)	9 2009 32. Rygistra	r's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year ELOISE C. HOLLMAN November 15 2009 10:34a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death HOWARD CO. APT 53 5680 STEVENFOREST RD COLUMBIA 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2**XX**F SEPT. 5 1935 MARYLAND <u> 218-36-8163</u> Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2XXNo MARYLAND HOWARD CO COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5680 STEVENFOREST RD APT 53 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ANO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛂 No Specify: BLACK 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade HOUSEWIFE HOME CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MILTON JOHNSON SR. IRENE CRAIG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry D. Hollman/Son 5694 Thicket Lane, Columbia, Md., 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 11-20-09 BALTIMORE, MARYLAND 21. Signature of Toreral Service 150 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Oroler 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Dav Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, II & Me. once.

Physician

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Examiner

Director

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Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manyler of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Mor) th, Day, Year)

State

31. Date filed (Month, Day, Year) NOV 19

IMPAGLIATELLI 1915. EATON St. 32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Attending Physician: The law requires that the death certist death. Ardeath. ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director.	hysiclan/M	IF FEMALE: 23b. Was deceder		23c. If yes, outcome	of pregnancy 2 Fetal death	3 Ectopic pregnance	CV/		23d. Date of	
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Physician: The this certificate I ral director, page	o Be	25. Was case refe examiner? 1 X Yes	The	Hospital:	ent 2 🗆 EB/Out	patient 3 DOA Oth	har:	ath (Check only o	one) idence 6 □Other (S	2000/6/1
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r Atte er dea recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		iry - At home, farr	n, street, factory, office		28f. Location (Street and Number or wn, State)	Rural Route Number,
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		30. Name and add	dress of person wh	no completed cause of de	eath (Item 23a) (1	vpe. Print)	004196	6	1.1. 7.	2009
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State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stevie R.L. Jeffery, Sr. November 6, 2009 12:25 р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
St. Mary's County Examiner St. Mary's Hospital Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex. 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-76-1364 6-21-1957 Washington, DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Anne Arundel MD. Severn 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21144 U.S.A. 1749 Old Georgetown Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Computer Network Engineer Government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ည Willa Jeffery Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1749 Old Georgetown Ct. Severn, Maryland Stevie R.L. Jeffery - Son Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State Washington Nat'l Cem. 11-14-2009 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardio Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hepatic Failure Sequentially list conditions, if any, leading to in models cause. (Size and a rilling) Exami Hepatitis C Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 1 Yes 2 No al or Attending Physician: TI s after death.
I Director: After this certifical od in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier 'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records,

Pt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37087 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JANKINS** LILLE ALVIN VOVEMBER 3: 48AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A UNION MEMORIAL HOSPITAL BALTIMORE 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days COUTRGINIA 89 1 □ M 2 🛣 F 217-88-3194 $9^{\frac{Month}{2}5} = 1^{\frac{Day}{2}} = 1^{\frac{Vaar}{2}} = 0$ Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f MD BALTIMORE WHITE MARSH 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4284 CLYDESDALE AVENUE 21211 items 23a U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: WHITE "natural", 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 lth and Mental Hygiene. 27 is marked other than * life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဨ JOHN FARMER (ROSE) 19a. Informant's Name/Relationship (Type, Print)
PATSY JANKINS/ DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 GOLDEN RING ROAD ROSEDALE, MD permit. Page 1 and 2 sh
Department of Health ar
Important: If Item 27 is
any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other p 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 11-20-09 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ACUTE MYOCARDIAL Physician/ (ZO MIN disease or condition resulting in death) Medical Examiner CORONARY > 10 YEAR Secure tially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury HYPERTENSION >10 YAARS physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d, Date of delivery Box (in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has autopsy performed? Yes 2 N 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 2 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural the Hospital or Attending hin 24 hours after death. the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division ☐ Accident Investigation completed filled in by the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

State Registrar

te 31. Date filed (Month, Day, Year) NOV 1 9 2009

mi Kullaum,

KU LIGARNI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNDN MEMORIAL MOSPITAL, BARTIMORE, MA Denn S. Sand

AT 2438946

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	St	ate of N	/laryland		rtmen tificate			and M	ental Hyg	gien 2 Neg. No.	009	3 7	7088
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Exar	mine	Manor Can	-		",				imore			40.	Journey or Bou		
Funer	ral	5. Social Security Number	6. Sex		Age (In yrs. I	ast birthday)	If Under		if Under	24 Hrs. Min.	8. Date of Birth (Month, Day) (Vear)	9. Bir	thplace (S	itate or Foreign
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and		Usual Residence of Deced	County		10c. City	, Town or Lo	cation							10d. Insi	ide City Limits
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toms	Filheral Director	11. Marital Status	12. W	as Deceder med Force ☐Yes 2	nt Ever in U.S \$?	S. 13. \	Vas Deced Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		an,
72 hours after natural', or I	2	1 Never Married 2 3 □ Widowed 4 □ D	☐ Married 1	☐Yes 2.5 Yes, Give ear or Date:	☑ No s:		I□Yes 2	₩ No	Specify:				Specify: b]	Lack	
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12 should ba and Mental is marked or	F	19a. Informant's Name/Re		rint)		19b. Mailin	a Address	(Street a			Il Route Numbe	r. City or	Town. State.	Zip Code)	
0 = -		Vernette Pee									ad Rand				21133
of Hear		20a. Method of Disposition			200	lace of Dispo	sition (Nan	ne of ther place	9)	С	ate	20c. Loc	cation - City or	Town, Sta	ate
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permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	once.	21. Signature of Euneral S Rona	S. Wad	e st	rector						655 W.	Ba1	timore	Stre	et
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w requires baan sign should be	4 Pa										1 🗆 Y	′es 2[]No 3□P	robably	4 Honknown
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The ate his page											perfor	rmed?	death? 1 ☐ Yes		
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To ti To ti	2	29b. Signature and title of	certifier			AA T	290		number	,		29d. Date	e signed (Mon	th, Day, Y	ear)
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		30. Name and address of SHOA113 A	1100	ted cause o	f death (Item	23a) (Type,	Print)	UTF	100	ST	Snite	308	13ALTI	mari	E m1)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Kenneth E. Jordan November 12, 2009 11:30 P.™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5409 Park Road Anne Arundel Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sev 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Months Min Days 1 XM 2 □ F 77 11/21/1931 218 26 3820 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show event, the Medical Evanimer rust be notified at 1 ☐ Yes 2 XNo Director Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5409 Park Road 21225 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status affled within 72 hours after deal Hygiene. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 White 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Machinist marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glen Jordan Mary Obzut ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 Robert Jordan / Son 5409 Park Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 11/17/2009 Baltimore, Maryland Cedar Hill Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Lift only one cause on each line. Immediate Cause (Final **Physician** hp disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last anding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ANo 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date şigned (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 ECHO. ND Maryland Registrar's Signature 31. Date filed (Month, Day, Registrar

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State of Manyland / Department of Health and Mental Hygiene

		•	1 - State OT Ma State Registrar	aryiand / Depa Cer	artment of He tificate of De	aith and iv ath	lental Hyg	eg. No.	37090
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		-		2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er	Vantage House		Columb				vard
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9. B	rthplace (State or Foreign
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	the h	Ω	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	country?
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	death item	Fu	11. Marital Status 12. Was Decedent Every Armed Forces?	ver in U.S. 13. V	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	after al", or xami	d by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 If Yes, Give 3 ☒ Widowed 4 ☐ Divorced	No 1	☐ Yes 2 X No 5	Specify:		Specify:	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21 Separation of Funeral Service Licensy.	22 L 1	Name and Address of emmon Fune O W. Padon	ral Home	e of Dul	aney Vall	ey Inc. 1093
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4 eco	he law te has b	Completed	prings				24a. Was an autops perforn	y prior to ned? death?	utopsy findings available completion of cause of
<u>=</u>	ian; T rtifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place	of Death (Check		THO I	2 110
5	hysic his ce	인	1 ☐ Yes 2 No Hospital:	ent 2 ER/Outpatien	nt 3 DOA Other:	4 🗶 Nursing Ho	me 5 🗆 Reside	nce 6 Other (Spe	cify)
on of	inding P ath. r: After t ie funera	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigation	y 28b. Time of injury	28c. Injury at work? M 1 \square Yes	s 2 🗆 No	28d. Describe ho	w injury occurred	
Division of Vital Records,	il or Atte after de Directo d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of responsible to the best of th	amination and/or invest	igation, in my opinion, o	death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	vithi Com	_	29b. Signature and title of certifier	D	29c. License nu		29	9d. Date signed (Mon	
	.0		30. Name and address of person who completed cause of de		· · ·	201		1.0 y Ombot	,,
	10			ton Avenue	, Baltimor	e, Mary	land 21	229	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registry	's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State	Certificate of	of Death	,,,	Reg. No.	200	9 3/09
Physicia		gistrar . Decedent's Name (First, Middle,Last)			Mon	of Death th Day	Year	3. Time of Death
ledical Examin		Donald Lacour	se		Nov	ember 7, 20	09	2226 hrs
	4	a. Facility Name (if not institution, give street and	I number)	4b. City, Town, or Location	on of Death		County of Death	
		1 W. Conway Street Apt. 616		Baltimore			A/N	
Funeral		. Social Security Number 6. Sex	7. Age (In yrs. last birthday)				D/YYYY) 9. Birth Foreign	place (State or
Director)12-52-9634 XM 2	F 49 Y	rs. Months Days Ho	ours Min. 04	1/16/19	60 Cou	ntry) Masa.
		Isual Residence of Decedent						
any		0a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
nd Show	اج	MD N/A	Baltim	nore				1 X Yes 2 No
Aaryland 28a-f show 1 at once	Director	0e. Street and Number		10f. Zip Code		10g. Citiz	en of What Count	try?
th the Maryland 23a or 28a-f she notified at once		west Collins Str	eet Apt.616	21229		U.S	5.A.	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sh at Examiner must, be notified at once	la	Marital Status 12. Was	Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexic			 Race - Americ White, etc. 	an Indian, Black,
death r iten	Funeral	Never Married 2 Married 1 X Y		res, specify Cubari, Mexi-	can, rueno rucan,			
after al", o	ᆰ	Widowed 4 Apivorced If Yes, Give or Dates:	Year 1	Yes 2 X No spec			Specify: Whi	
nours natur Xam		15. Decedent's Education (Specify only highest	during	ent's Usual Occupation (G most of working life. DO N	ive kind of work do IOT use retired)	ne 1166. K	ind of Business/Ir	idustry
16 n 72 l nan ",	Completed		ge (1-4 or 5+)	onanga Una		FI	ooring	Company
5-003(led within Hygiene. other tha	틹	7. Father's Name (First, Middle, Last)	ars Maic	enance Eng	ther's Name (First,			Company
			Lagourge		anche	Lema		
12 Id be Aenta narke		Gerard 9a. Informant's Name/Relationship (Type, Print	Lacourse 19b. Mail	ing Address (Street and		oute Number, Ci	y ty or Town, State,	Zip Code)
O 등 5 : 2 : 3	— ï	Sherry Teycer (Dau		Taylor S				
- = 8 = :		20a. Method of Disposition	20b. Place of Disp	osition (Name of cemetery			Location - City or	Town, State
		1 Burial 2 X Cremation 3 Remove	ral from State Joseph	other place) Brown F/H ematory	11/19	/09 Ra	ltimore	MD
timen rtant	-	Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	and Cre	Name and Address of Fa				
Baltimorr permit. Pages I Department of I Important: If		final service Electrises	() Murins	Name and Address of Fa 105eph H. 2140 N. Fu	Brown J. Iton Ave	r. Fune Bal	eral Ho Ltimore	me ,MD 21217
Physician	\dashv	23a. Part I. Enter the disease, or complications the	nat caused the death. Do not ente	er the mode of dying, such	as cardiac or respi	ratory arrest, sho	ock, or heart	Approximate Interval Between Onset and
/Medical	ı	failure. List only one cause on each line.	cotic intoxicat					Death
taminer	1		as a consequence of):	.1011				
		Sequentially list conditions, b						
	le	f any, leading to immediate Due to (or cause. Enter Underlying Cause	as a consequence of):					
0.	Examiner	(Discoss or injury that initiated C.	as a consequence of):					
executed ian and ial - transit		d						
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760, cate be exphysician the burial	ğ l	F FEMALE: 23c. If	yes, outcome of pregnancy			23	d. Date of deliver	·
687 ertific ding p		nast 12 months?	ive birth 2		ctopic pregnancy		Month I	Day Year
Box 687 e death certifie the attending ed for use as t	Physician	4 Ves 0 No 0 Unknown	Pregnant at time of death 5	Other (Specify)				
D. B. : the de by the ached f		Part II. Other significant conditions contribut		ne underlying cause given	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
i, P.O. ires that the signed by I be detach	<u>a</u>	Cirrhosis of liver				1 Yes 2	✓ No 3 Pro	bably 4 Unknown
S, quires en sig	ted	CITTHOSIS OF TIVEL		<u> </u>		24a. Was an		utopsy findings available
OFC aw re as be 2 shor	elle					autopsy performed?	death?	completion of cause of
Rec The L	Completed				1	✓ Yes 2	√ 1 ✓ Y	es 2 No
Vital Records, ysician: The law requiin his certificate has been to director, page 2 should	Be	25. Was case referred to medical examiner?		Othe	eath (Check only o		- 4 011	
Vit hysic this o	P	1 ✓ Yes 2 No	Inpatient 2 ER/Outpat				ence 6 Othe	er: Scene
of Viling Physical After this		1 Network	Date of Injury 28b. Time Month, Day,Year)	of Injury 28c. Injury at		Describe how in	jury occurred	
ion ttend death.	atie	2 Accident Pending Fd		:1/ pm			and Niverban on D	ural Bouta Number City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide Could not be	Place of Injury - At home, farm, s	street, factory, office buildir	ng, etc. 28f.	cocation (Street or Town, State)	1 W Conw	ural Route Number, City ay St. Apt
Spital cours are al	S	4 nomicide	house		616		more, MI	
n 24 h		(Check dill)	e best of my knowledge, death or asis of examination and/or invest	ccurred at the time, date ar tigation, in my opinion, dea	nd place, and due t ath occurred at the	to the cause(s) a time, date and p	ind manner as sta lace, and due to t	ned. he cause(s)
Division of V To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After it	Medical	and mar	ner stated.	29c. License nu			. Date signed (M	
	2	29b. Signature and title of certifier	1	O.C.M.E			vember 8, 20	
1/1/2		Migane Vhe While	(
ON SEUCY.		30. Name and address of person who complete		1 Penn Street, Baltir	more MD 212	01		
V+ YV				i i eiii Gireet, Daltii	11016, 1110 2 12	- · · · · · · · · · · · · · · · · · · ·		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	arked				
- Kegisi		MILL A LIMB	CARLES A CY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 200 Novembe 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Days Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 Yes 2 No mor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aintenanc ontro 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wite raonne 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Funeral Service Lice 23a. Part 1 Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years ownary Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventherm.

Hostige for Attending Physician: The law requires that the death certificate be executed 24 hours after death. Perfector: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examiner lical

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🗆	s, outcome of pregna Live birth 2☐ Feta Pregnant at time of c Unknown	Il death 3 🗆 Ector				23d. Date of delivery Month Day Ye ar
Part II. Other significant cond	itions contributing	to death but not res	ulting in the underlyi	ng caus	e given in Part I.	/	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
						24a. Was an autopsy performed 1 Yes 2	
25. Was case referred to medi-	cal				26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 Inpatient 2	ER/Outpatient 3] DOA	Other: 4 \(\sum \) Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pend 2 Accident investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury M		Injury at Work? 1 □Yes 2 □No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rminod 286.	Place of Injury - At he building, etc. (Specif	ome, farm, street, fac fy)	ctory, off	fice	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	al Examiner: On						e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

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29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

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29b. Signature and tit

ye flennam.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 0437 M 2009 NOU /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Agnes Hospita 3=1+imore 9. Birthplace (State or Foreign Pountry) Naryland 5. Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Aug. 23 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Months Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantiner must be notified at any injury or other traumatic event, the Modical Evantiner must be notified at optice. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tt 130 2 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Blac 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 4 Donation 5 Dother (Specify) 22. Name an Uddress of Facility OSEAN L. RUSS 2271 W. NOCTH 21. Signature of Fundral Service Licenses mergy no. 21216 ate AVE. 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep515 1)0 / /Medical Due to (or as a consequence of): Examiner peritonit Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Colonic as the burial-tran the attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Year Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed PIVISION After Hospital or Attending Physician: The Hospital or Attending Physician: The Attending Physician and P 2 No Vital 1 □ Yes 2 □ 1 1 1 1 1 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P23574 November, 17, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DAVID

CALVIN

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#24a, perPHYS#16a, perFH, g897, 111, 19709, WS
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sharon Alice Lasher 14.14 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 (In yrs. last birthday) 52 v-If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 9 1 □ M 2 🛱 F Months Davs Hours March 14,1957 County aryland **Director** 218-66-1651 6103 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Examiner must be notified at Director Littlestown 28a-f Penn. Adams 1 Yes 2X No 0 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 17340 U.S.A. 1264 Fish and Game Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White SI 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Regits Persua retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Register Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norma Ann Jackson George Richard Lasher SHARON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1264 Fish and Game Rd. Littlestown, PA. 17340 Norma Ann Sapp - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 19,2009 Metro Crematory Nov. Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Elex Hat. 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PHEUMONIA Medical resulting in death) Due to (or as a consequence of) Examiner PERFORATION SIGMOID Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Due to jor as a consequence of and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last LUPUS that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year ed by the detached 1 ☐ Yes 2 ₩ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SJOGREN Vital Records, MYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending ARON Accident
Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOD 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD, 21239 RAVEN BLVD LOCH 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2009 37095 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOVEMBER 15 200 Katherine D. Langellotto Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PACTIMORE WASHINGTON MEDICAL CHEN BURNIE AMMA **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □XF Months Days Virginia 219 10 5302 91 Month Bay, 71918 Director Usual Residence of Decedent permit. Page 1 and 2 should be file: within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked on ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 163 Mountain Road 21122 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tavern Owner Self employed 8th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANGELLOTTO ည James Albert Langellotto Katherine DiHiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Langellottto 684 - 207th Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/20/2009 Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease shock, or heart failure. List on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant 9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performed Director: After this certificate 1 Yes 2 No Yes 2 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ပ္ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu ☐ Accident 1 \square Yes 2 🗌 No Investigation ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 45149 2009 ddress of person who completed cause of death (Item 23a) (Type, Print) 9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, 25,27,28a-f per me, 2897,11/19/09dhb

Certificate of Death

Reg. No. 4 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Matthew E. Mitchell Jr 1, 2009 November 6:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Candlelight Cove Easton Talbot 5. Social Security Number 9. Birthplace (State or Foreign Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Sept 13, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1921 Months Days Hours Min 11√2 M 2□ F 213-18-6231 88 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinan must be notified at 1 ☐ Yes 27 No Director Talbot St. Michaels MD with the 10e. Street and Number 10g. Citizen of What Country? USA 21663 24700 Deeptwater Point Dr #2 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It a IM once. Elementary/Secondary (0-12) College (1-4or 5+) real estate title examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matthew Mitchell Sr Anna Skirman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty E. Mitchell/spouse Box 418 St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 -Wade 655 W. Baltimore Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent of): Examiner W04 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical CERTIF IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 □ Yes 1 ☐ Yes 2 ☐ No of Vital funeral director, 25. Was case referred to medical examiner?
1 A Yes 2 100 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending 1 D Natural 2 **X** Accident October Day, 5 Pending investigation after death.

Director: Af
d in by the fur Unknown M Subject fell 1 ☐ Yes 2 X No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Assisted Living Facility 28f. Location (Street and Number or Rural Route Number, City or Town, State) 106 W. Earle Avenue filled in by 4 Homicide Easton, Md 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 11-06-2009

Registrar DHMH 17 Rev 1/2001

State

Guwood

555

32. Registrar's Signature

or

Easton MA 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RISE(() A Schiller BD 555 Chuk

2009 9

31. Date filed (Month, Day, Year)

9-08790		Please Type or Print in Black Indelible Ink. Ensure All Co	pies Are Legi	ble.	
lichael Anthony	1	adden AmendState of Maryland Desagtimen; 25 health and Mental Certificate of Death	Hygiene Reg.	No. 20	09 3709
Physicia	1/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month D November 1	Day Year	3. Time of Death 2053 hrs
Medical Examin		Michael A. McFadden 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D		4c. County of Death	1
		University Hospital Baltimore		N/A	
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8 Date of Birth. 03/24/1	(MM/DD/YYYY) 9. Bir 1958 Foreig	thplace (State or gn
Director	2	06-46-8424 1XM 2F 51 Yrs. Months Days Hous	03/24/	2009 C	ountry) PA
>	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ow any		MD N/A Baltimore			1 X Yes 2 No
Maryland 28a-f show d at once,	황	10e. Street and Number 10f. Zip Code	109	g. Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once.	Director	2010 W. Lanvale Street 21217		.s.A.	
ms 23	_ L	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	14, Race - Ame White, etc.	rican Indian, Black,
or ite	핊	Never Married 2 X Married 1 Yes 2 X No		Specify:Bla	ck
urs afte	좕	or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin	I O OI WOUL GOLLO	16b. Kind of Business	/Industry
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	se retired)	Contrac	tor
9036 within iene. er tha	Completed	2 Years Electrician	Name (First, Middle, M		
21215-0036 build be filed within 72 hours ai Mental Hygiene. marked other than "natural c event, the Me fical E samin	ادہ	17. Father's Name (First, Middle, Last) Raymond McFadden Lill:		Hanna	
D 21215-00. should be filed with and Mental Hygiene 77 is marked other in natic event, the Me	10 B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			
and 2 should tealth and Me tem 27 is mar traumatic ev		Lisa McFadden (wife) 12 Plater Ct., 20a Method of Disposition 20a Method of Disposition (Name of cemetery.	Baltimore Date	MD 212	or Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimore, permit. Pages I as Department of Hei Important: If ite		4 Donation 5 Other Specify:	11/20/09		
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.	-	La field Milliam 2140 N. Fulto	wn Jr. Fu n Ave., E	neral HC Baltimore	MD 21217
Physician	┪	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one cause on each line.	rdiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
'M dical aminer	1	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death
		or condition resulting in death) Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate out to (or as a consequence of): Due to (or as a consequence of):			
V	Examiner	C. Due to (or as a consequence of):			
executed an and and al - transit	cal Ex	d			
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Box 68760, e death certificate be the attending physici ed for use as the buil	Physician/Medi	neet 12 months?	pregnancy	Month	Day Year
DX 6 ath cer attendi	sicia	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown		234.1	İ
Division of Vital Records, P.O. Box 68760, spiral or Attending Physician: The law requires that the death certificate be extended after death. After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part			to the cause of death?
Division of Vital Records, P.O. In or Attending Physician: The law requires that the reduction of After this certificate has been signed by the funeral director, page 2 should be detach led in by the funeral director, page 2 should be detach	d by			s 2 No 3 F	
ords v requi s been should	Completed		24a. Was		e autopsy findings available to completion of cause of
Recc The lave cate ha	mo		1 🗸 Yes	2 No 1 🗸	
tal Frian: Certific	BeC	25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 4. Inpatient 2 FR/Outpatient 3 DOA Other	(Check only one) Nursing Home 5	Residence 6 0	ther:
f Vid Physic er this ral dire		examiner/ 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28. Injury at Work 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work	? 28d. Describe	how injury occurred	
nding th. re Afte	ion:	1 Natural 5 Pending Nov 12, 2009 2014 hrs 1 Yes 2			
/ision r Attendi ter death. irector: n by the f	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et	c. 28f. Location ((Street and Number of State)	Rural Route Number, City
Divis Bospital or A 24 hours after Funeral Dire	Certification: To	4 ✔ Homicide determined (Specify) Local Street		State) andvale Street, Ba	
Hos Fun fely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat (Check only one) 2 Medical Examiner: On the basis of examination, and/or investigation, in my opinion, death occurred.	ace, and due to the cau curred at the time, date	ise(s) and manner as e and place, and due t	stated. to the cause(s)
To the Vithin 2 To the Complete	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
()		0.C.M.E.		November 13	, 2009
DX.		30. Name and address of person who completed cause of death (Item 23a)	MD 04004		
	e /	Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, I	VID 21201		
S Regis	tate tra	4 O THUNK I H ANDEZ PET 11			

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AMEND TTEM#5perFH, G898, 12/4/09, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar 37098 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gertrude E. Matthews 12:20 November 2009Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10307 Night Mist Court Columbia Howard ocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** (Month, Day, Year) -25-1928 1 □ M 2 🕅 F Months Days Hours Min. Yrs Director 81 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Completed by Funeral Director 1 Yes 2X No MD Howard Columbia 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a 10307 Night Mist Court 21044 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Yes, Give Specify: African-American "natural", 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baker Leidig Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Edmond Brittis Edmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8617 Licerne Road, Randallstown, MD 21133 leonard Matthews/Son Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: If any injury or once. Columbia <u>Memorial Park</u> 11-20-09 Columbia, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Licensee nandow 9200 Liberty Road, Randallstown, MD 21133 23a. Part . Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical fie to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant a Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KONIC KIDNEM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 \sum Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Medical Certificate: 28d. Describe how injury occurred injury 5 \square Pending Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) the Hospital 1
1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my calcing death account of the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEWE DICEMANIMO 6701 NEMAPLES ST, SUITE 4185 BALTIMORE, MD 21204 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

MCKINney, 12odneyの Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	•	For State Registrar	Olale of	iviai yiai		partment of F ertificate of		iu ivientai i		2009	370
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/sicia: ledica		Rodney G. McF	Kinney					Month	/ 2		_ ()
mine		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, o	r Location of I	Death	4c.	County of Dea	
		FRANKLIN SQU	cre Hos	pital	Cente	r Ros	edal			Balti	more
rai		5. Social Security Number 219–40–7582	6. Sex 7 1 XD M 2 □ F	Age (In yrs.	last birthd: Yrs	Months Days	If Under 24 Hours	Min. 8. Date of	Birth Day, Year)	4.2 9. Bir	rthplace (State or country)
tor	1	Usual Residence of Decedent		66				NOV 2		42	
Tourned at		10a. State 10b. County		10c. Ci	ty, Town or	Location					10d. Inside City
MINE	Director	MD			Bal	timore					1 X Yes
	Dire	10e. Street and Number	•			10f. Zip Code	1.0		10g. Cit	izen of What C	ountry?
	Funeral	1120 Stevens Dr				212				USA	
	-un	11. Marital Status un 1 ☐ Never Married 2 ☐ Marrie	Armed Forc	es?	unk 1	Was Decedent of H If Yes, specify Cuba	lispanic Origir an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whit	
	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 □Yes 2 ∏ No	Specify:			Specify: Wh	nite
	ted	15. Decedent's	s Education		16a. De	cedent's Usual Occup	ation	unk	16b. Ki	ind of Business	s/Industry 1
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	Н	19a. Informant's Name/Relationship				ailing Address (Street					· - ·
once.	1	Franklin Square 20a. Method of Disposition	HOSPITAL	20b. I	lace of Dis	0 Franklin position (Name of rematory or other place	<u>Squar</u>	e Drive]	Roseda 20c. Lo	ale, MD ocation - City or	21237 r Town, State
		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Conation 5 ▼ Other (Spe	Removal from St		cemetery, d	rematory or other plac	ce)			, ,	
انو	1	21. Signature of Lineral Services on a La		10		22. Name and Addre	ss of Facility	1 (55 1	7 D 1		a
g		Ronald	. wade of	recto		State Anat Baltimore,			v. ват	timore	Street
110	Exa	Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or	as a consequence as a c	uence of): uence of):	remia					
Medical Certification To Re Completed by Dhysician/Medical	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	th 2 Teta	ıl death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		_	23d. Date of de Month	elivery Day Ye
4 5	≥	Part II. Other significant condition	s contributing to deal	h but not res	ulting in the	underlying cause giv	en in Part I.				to the cause of de Probably 4 ☐ Ui
1 2	Completed							j p€	as an itopsy erformed? s 2 No	prior to death?	utopsy findings a completion of ca s 2 \(\sum \text{No} \)
Comp		25. Was case referred to medical examiner?	Hospital:	otion: 0	ED/2 :	ient 3 □ DOA Oth	or:	Death (Check onl			
Re Compl	ge Re		1 Minp	Injury	28b. Time	of 28c. Injur	4 LJ Nursi	ng Home 5 ☐ Ro 28d. Descrik			ecify)
n. To Re Commi	ge Re	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	uay, Year)	Injur		∛? Yes 2 ∐No		•		
a	ge Re	1 Yes 2 No	(Month,	,, ,,	ļ	_		I			
Partification To Be Commi	ge Re	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	(Month,		ome, farm,	street, factory, office		28f. Location City or	n (Street an Town, State	nd Number or R	Rural Route Numb
odical Certification: To Be Compl	Certification: Io Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine 29a. Certifier 1 Certifying	ttion at be led 28e. Place of building Physician: To the bu	Injury - At he, etc. (Special section of my known of examinal section of examination of examinat	y) owledge, de		me, date and ppinion, death	City or i	Town, State) and manner a	as stated.
Medical Certification: To Re Completed by Dhysic	legical Certification: Io Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine 29a. Certifier 1 Certifying (Check only 2 Medical Ex	tion t be led 28e. Place of building Physician: To the be xaminer: On the bas	Injury - At he, etc. (Special section of my known of examinal section of examination of examinat	y) owledge, de	street, factory, office	pinion, death	City or i	the cause(s) and manner a	as stated. e to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Muchler 12:43 A M November Louise Η. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Havre de Grace 200 Spectacular Bid Drive If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F Months Hours (Month, Day, Year) ec 1. 1919 **Director** 187-05-7309 89 Dec Pennsylvania Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marking or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 🕅 No Maryland Harford <u>Havre de Grace</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 200 Spectacular Bid Drive 21078 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 \square Never Married 2 \square Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 - Widowed 4 X Divorced Specify. Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Musician/Organist 04 Religious Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Davis Howe11 Carrie Datesman Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Hallett/Daughter 200 Spectacular Bid Drive, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/23/09 Burial 2 Cremation 3 Removal from State 4 Departion 5 Other (Specif Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clar 23a. Part 1 Enter the disease, or complica ions that ca used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart ailure. List only one Immediate Cause (F nal Onset and Death Physician/ Neuroendocrine disease or cond resulting in deat kast Medical Due to (or as a consequence of): Examine Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 😿 No Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 WNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? / oronar 24a, Was an autopsy performed?.

Yes 2 2 No **Director:** After this certificate in by the funeral director, pag 2 No 1 Yes To Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a
To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

NOV 1 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sean Michael Curtin, MD

D0052578

615 W. MacPhail Rd., Suite 105, Bel Air, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perater of Rankylah 20 692 rt Hent of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wembe Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day 1 □ M 2 🕅 F Hours Min. Country) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Yes 2 No If Yes, Give Year or P Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Rural Route Number, City or 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) orast Hill 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death NG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the Edward Cause (Disease or linjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 유 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A Other (Specify) NOSP (4 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month,

2.

6701

Registrar's Signatu

Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES

Novem Ber

TONSON

17 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death **Physician** Jovember 15 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, 10102/14 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X** M 2□ F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, It a Modical Examiner must be notified at 1 Yes 2 □ No Director 28a-f 10e. Street and Number 0f. Zip Code 10g. Citizen of What Country? natural", or items 23a or Harford 21214 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1216 Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be မ Important: If item 27 is any injury or other tra once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lifensee 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherisclinite **Physician** Carda Vischler disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ang physician and e as the burial-trans Due to (or as a consequence of): O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Year 5 ☐ Other (specify) 1 ∐Yes 2 12 No 9 🗌 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☑No 24a. Was an certificate 1 □Yes 2 ☑No of Vital the Hospital or Attending Physician; completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 ₹No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person

Servers

Year)

5601 Loch Raven Boulevard, Baltimore Maryland 21239

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

November 17,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Dece**j**lent's Name (First, Middle, Last) 2) Date of Death 3. Time of Death Physician/ Month 2:45 PM Wembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 If Yes, Give 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Alental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1111 . Signature of Funeral Service Licensee 22 Name and Add Monkitan Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine 1ABETE and Due to (or as a consequence of) resulting in death) Last bunalattending physician for use as the buna Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown the detached 9 Unknown P.O. I þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 🗌 No 1 \square Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{align*} \text{Lother} \) Other (Specify) 2 KNo 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the funeral prompleted filled in by the funeral prompleted filled in by the funeral filled in by the funera Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar only one)

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUBERMAN, MO

32. Registrar's Sign ture

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

6701 N CHARLES ST, SUITE 4105 BALTIMORE, NO 21204

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiede U U 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Carlo M. Peduto 10:10 PM 2009 Nov. 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford County Hart Heritage Forest Hill | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 1, May 1, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 226-05-8218 1**X** M 2□ F Virginia 91 1918 Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23e or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland Harford County Forest Hill Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1913 Rock Spring Road 21050 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 δ 3 Widowed 4 □ Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Government Federal Protective Services permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any liury or other traumatic event, 900s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carmen Peduto Philomena Pepino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
234 Rachel Circle, Forest Hill, Maryland 21050 19a. Informant's Name/Relationship (Type, Print) Debbie Peduto (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 11/17 2009 Forest Hill, Maryland Evans Funeral Chapel * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Belai Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Benentin END STAGE Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien end hed for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Heart Frilare mustive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed ddisons 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has le 2 certificate 1 Yes 2 □ Ne To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) CARR 1 Yes 2€ No ٩ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending s after decree el Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NOV 16,2009 31889 MD

State Registrar

31. Date filed (

Company Signatura Comment

W. MARPHAIL BEL AN MUS 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 10, 2009 30 a M Pleasar James 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b City, Town, or Location of Death General Ractimore Maryland 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F -8798 177-16-Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Des 2 No Marylar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Care 1526 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ₩No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Valley Motos Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James 19b. Mailing Address (Street and Number or Bural Route Nu er, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pleasant 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one made on each line. Immediate Cause (Final disease or condition resulting in death) men Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Year Day 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy 2 12 No 1 Yes 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending p certificate has been signed by the irector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဂ

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner is ust be notified at agree.

Physician /Medical

Examiner

physician and the burial-trans

Baltimore, Maryland 21215-0036

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

the

State Registrar 29b. Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ansurd

31. Date filed (Month, Day, Year)

and title of certifier

300 ARMORI Registrar's Signature

and manner stated.

ATTEMDING

29c. License number

0056948

29d. Date signed (Month, Day, Year)

Place Swife 3H Balb., md. 21201

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Nancy J. Quanstrom 2. Date of Death **Physician** 13 OC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Care Center Parkville Oak Crest g. Birthplace (State or Foreign Country) Wyoming If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 14, 1921 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 👽 F 87 Yrs. Director 558-20-9615 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Parkville Director 1 ☐Yes 2 ☐No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8800 Walther Blvd Apt. 3001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑₩☐Yes 2☐No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 à 1 □Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Career Navy Wife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Mae Finke Frank Arthur Falls ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 8800 Walther Blvd Apt. 3001 Parkville, MD 19a. Informant's Name/Relationship (Type. Print) Carl Quanstrom-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel
and Cremation Ser, Belair 1/01/15, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services LME Condiae add 8800 Harford Road-Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DNEWMONIA /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tra Due to (or as a consequence of) P.O. Box 68760. The law requires that the death certificate be Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached q | Unknown 9 Unknown ģ signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 🗌 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes Physician: director, Be 25. Was case referred to me examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of Injury 27. Manner Ceath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation atural 1 ☐ Yes 2 ☐ No Accident 24 hours after deat Funeral Director; filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the within To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 9,2009 James Royal evember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PERRY Point If Under 24 Hrs. Min. Health are CC1 Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Director 577-72-1300 55 3-1-1954 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once. Director 1 XYes 2 ☐ No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5801 Reisterstown Road 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Aves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates:1971-1975 1 ∐Yes 2 DNo Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Auto Mechanic Private 12 should be filed w th and Mental Hygien 7 Is marked other th and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur James Royal Martha Louise Oates ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 5801 Reisterstown Rd. Baltimore, Maryland 21215 Beverly K. Royal - Wife timore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Pk Crematory 11-18-09 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Ronald Taylor II Funeral Home 21. Signature of Funeral Service Licensee Bal COMO 108 W. North Avenue, Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of) PONTO CEREBELLAR DEGENERATION VOKACION Examiner VO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an has autopsy performed? Yes 2 \(\square\) No this certificate 1 XYes the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide n 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Physician: Royal, James

2

James

32. Registrar's Signature

HEZITH CARE System, PERRY Point,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Santos

MEIECIA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician oger 2009 November /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs 9. Birthplace Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** 1 ■ M 2 👿 F Yrs. North Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) orkea 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type. Print) (sister) 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 22. Name and Address of Facility Toseph L. Rus 21. Signature of Funeral Service Licenses Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6mi /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ sate has been signed page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 ⊡No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ №6 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 30. Name and andress of erson who completed cause of death (Item 23a) (Type, Print) MERLITT 25 MAIN ST. REISLERSTOWN, MD 21136 KAREN W

Registrar

State

31. Date filed (Month, Day, Year)

NOV 1 9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ANTON RADAKOVIC JR. 10:30A M NOVEMBER 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HARFORD 203 KIMARY CT APT. D 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-12-1925 **Funeral** 9. Birthplace (State or Foreign Months Days 288-16-7231 1 M M 2 □ F 84 Hours Min Director OHIO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the Midical Exemple roust be notified at MD HARFORD FOREST HILL 1 □ Yes ZHA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 KIMARY COURT APT D 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★★es 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1943-46 1 ☐ Yes 2 🙀 No ģ Specify WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BRICK MATERIAL Elementary/Secondary (0-12) College (1-4or 5+) FOREMAN BETHLEHAM STEEL marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTON RADAKOVIC, SR. ALICE (BUKSA) item 27 is marker other traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
203 KIMARY CT APT D FOREST HILL, MD permit. Pages 1 and 2 s
Department of Health ar
important; if item 27 is
any injury or other trau AUDREY B. RADAKOVÍC/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
OAKLAWN CEMETERY Date 20c. Location - City or Town, State 1 DrBurial 2 ☐ Cremation 3 ☐ Removal from State 11-17-09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S ice icensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. ned by the a 9 Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š within 24 hours after or To the Funeral Direct determined 4 Homicide

State

Medical

29a. Certifier

(Check only one)

29b. Signature and tilte of certifie

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square

9103 Waterfiel 31. Date filed (Month, Day, Year)

Registrar's Signatur 1 9 2009

and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

024356

the ADO Boltimore, MD 2123

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

Division of Vital Records, P.O. Box 68760, 24 hours after death. To the

29a. Certifier 1 (Check only one)

29b. Signature and title of certifier

Medical

State

Registrar

DHMH 17 Rev 1/2001

OCME 2006

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) gistrar's Signatur **ORIGINAL**

and manner stated

29d. Date signed (Month, Day, Year) November 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SMITH Physician/ 2:45 AM Novembe Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Glen Burnie 502 W. Furnace Branch Rd If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 - M 2 - XX 219-28-0005 Director Oct 18. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Glen Burnie MD Anne Arundel 1 ☐ Yes XXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 502 W. Furnace Brance Rd ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2xx Married 1 ☐ Yes 2 ☒MNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Freida Eva Blanker Harry Milton Kahmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 W. Furnace Branch Rd, Glen Burnie, MD 21061 Brent Smith Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD Bayv ew Crematory Nov 14, 2009 ture of Funeral Service Sign 22. Name and Address of Facility, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 Fink M01148 Gregory 23a. Part 1. Enter the disea shock or heart failure mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ICARS one cause on each line. Immediate Cause (Final Physician/ disease or con resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Proctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar

DHMH 17 Rev 7/2009

3

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KASAMON

only one) 29b. Signature and title of certifier

MD

KNOLL

5450

Registrar's Signature

29c. License number

DO0 58779

NORTH DR.

29d. Date signed (Month, Day, Year)

Columbia, MD 21045

November 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 17,2009 SYNODINO 8:30A M ANNT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WHITE 11702 LARCH ROAD MARSH 5. Social Security Number 8. Date of Birth (Month, Day, 8-31-1939 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funerai Months Days Min. 1 □ M 2 🗹 F 70 Hours MARYLAND 217-34-4414 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD WHITE MARSH Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11702 LARCH ROAD 21162 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1∐Yes 2∭XNo Specify. 3 Specify: WHITE 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN DIX UNKNOWN (UNKNOWN) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL SYNODINOS/SON 11702 LARCH ROAD WHITE MARSH, MD 21162 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL MEMORIAL CARDEN 11-20-09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ere of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bow disease or condition resulting in death) Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine eu resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 □ Yes 2 🗸 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

The law requires that the death certificate be executed burial-transit Box 68760. physician the attending pl P.O. the detached signed by t t be detach Records, cate has page 2 s certificate Division of Vital or Attending Physician: director, this After thi funeral e Funeral Director: Aft bletely filled in by the fun

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "necical Examiner in ust be notified in

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item any Injury or other traumatic event, Item any Jones.

Physician

/Medical

Examiner

with the Maryland fshow

within 72 hours after death

Maryland 21215-0036

Baltimore,

Certification: To

1 Natural 2 Accident

29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

(Check only one)

29a, Certifie

determined

6 Could not be

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEETA GULATI 31. Date filed (Month, Day, Year)

9649 BEL ATR ROAD

BALTIMORE, 21236 MD

State Registrar

Medical

NOV 1 9 2009

To the

To the Hospital

09-08860 Wilbert Tyler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Wilbert Tyler		State of	Maryland /	-	rtment of		d Mental Hy	-	2	000	2711	
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Jert	oato oi			2. Date of Death		3. Time	e of Death	
Medical Exami		Wilbert Ch	ristoph	er	Tyle	r		Month November	Day Year 15, 2009	044	48 hrs	
		4a. Facility Name (if not institution, give str				b. City, Town, or	Location of Death		4c. County of	Death		
		105 S. Kossuth Street				Baltimore			N/A			
Funeral		5. Social Security Number 6. Sex		(In yrs. las	st birthday)	If Under 1 Year Months Days		_		Foreign	(State or	
Director		214-50-7056 ¹ XM	2F	61	Yrs.	Monais Bay	Tiours IVIII.	12-25-	1947	Country)	MD	
any		Usual Residence of Decedent 10a. State 10b. County	- 14	IOo City 7	Town or Location	20				I 10d Jr	nside City Limits	
*		, , , , , , , , , , , , , , , , , , , ,	Į.							1	Yes 2 No	
yland a -f sh	tor	MD N/A 10e. Street and Number		Ват	timore	10f. Zip Code	_	110	g. Citizen of Wha			
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tent and Mental Hygiene tent "natural", or items 23a or 28a-f sho trammatic event, the Medical Examiner must be notified at once.	Funeral Director	10f. Zip Code 10g. Citizen or what C								Country.		
ith th	al D	105 South Kossut	. Was Decedent E		13 Was	212	29 panic Origin? (Sp		U.S.A.	American Indi	ian Black	
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ter de ", or er mı		3 Widowed 4 Divorced If Y	es, Give Yeer	X No	1	Yes 2 X No	specify:		Specify:	Black		
urs af tural amin	d by	15. Decedent's Education (Specify only h	Dates:	oleted)	16a. Decedent	's Usual Occupat	ion (Give kind of v		16b. Kind of Busi			
) 72 ho n "na al Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during mo	st of working life.	DO NOT use retir	red)				
036 ithin ne. r tha	mpl	12th Grade			N/A			•		bility		
5-0 led w Hygie othe	Col	17. Father's Name (First, Middle, Last)					18.Mother's Name	(First, Middle, M	aiden Surname)	mn-ur	known	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	unknown Jacob Street and Num unknown Ade 19a. Informant's Name/Relationship (Type, Print)											
D 2. should and M is m:	To	19a. Informant's Name/Relationship (Type	(VV	fe)	4				-			
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tanti. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		Oorothy Champion- 20a. Method of Disposition	-Tyler	20h D		tion (Name of cer		Date	et, Balto., MD 2122			
		1 Burial 2 X Cremation 3 1	Removal from Stat			erplace) Brown F	/11		•			
Baltimore permit. Pages 1 Department of H Important: If i		4 Donation 5 Other Specify:		An	d Crem	natory	111/	18/09	Balti	more,	MD	
Salt ermit Separt mpor njury		21. Signature of Funeral Service Licensee	201		22 N	seph H	of Facility Brown	Jr. F	uneral	Home	24247	
_ =====		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. Brown Jr. Funeral Hom 2140 N. Fulton Ave., Baltimore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									D 21217 roximate Interval	
Physician /Medical		failure. List only one cause on each li	ine.			101		respiratory arro	st, shock, or near		ween Onset and	
caminer			pertensive Ath			ovascular Dis	ease				Death	
		b	to (or as a consec	quence or,):							
	ĕ		to (or as a consec	quence of)):							
	直	cause. Enter Underlying Cause (Disease or injury that initiated	1. (_		
ast g g	Examiner	events resulting in death, Last	to (or as a consec	quence or;):							
execu in and	edical	UNPENDED X A	MENDED									
Box 68760, he death certificate be executed y the attending physician and hed for use as the burial - transit	ledi	IF FEMALE: 2	MENDED Pi	line	a per	ME g901	3/4/10	<u>rt</u>	23d. Date of o	delivery	- "	
Ox 6876(eath certificate attending phy for use as the the	Physician/M	23b. Was decedent pregnant in the past 12 months?	Live birth	o or progri	_	al death 3	Ectopic pregna	nncy	Month	Day	Year	
lox 6 eath ce attend for use	sicia	4 No. 2 No. 2 No. 2 Holeson		ime of dea	ath 5 Oth	er (Specify)						
. BC he des	hys						i D I	O2a Did ta	bacco use contrib	auto to the ear	see of death?	
that the dined by the detached	by F		ntributing to death	but not re	suiting in the u	ndenying cause (given in Part i.		2 No 3			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stater death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	eq	Diabetes; Chronic Alcohol A	buse					24a. Was a			indings available	
ords aw requinas been as been a	Completed							autop	sy pi	rior to complet eath?	tion of cause of	
Rec The Is icate h	E O							perfor 1 ✓ Yes		v Yes	2 No	
tal Reisian: The certificate	Be C	25. Was case referred to medical examiner?				26.Place	of Death (Check	only one)				
ion of Vital fending Physician: eath. or: After this certifi the funeral director,	.ol	examiner? 1 ✓ Yes 2 No	oital: 1 Inpatien	nt 2	ER/Outpatient	3 DOA	Other Nursir	ng Home 5	Residence 6 🗸	Other: Scene	e	
ing Pl	Ë	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y par)	28b. Time of Ir		ry at Work?	28d. Describe h	ow injury occurre	bd		
ion trend death tor:	atic	Natural 5 Pending Accident Investigation				1	Yes 2 No					
ivisi or At after d Direct	EE	3 Suicide 6 Could not be	28e. Place of Inju	ury - At ho	me, farm, stree	t, factory, office t	ouilding, etc.	28f. Location (S or Town, S	Street and Number tate)	r or Rural Rou	ate Number, City	
Divi Spital or nours afte	Certification:	4 Homicide determined	(Specify)									
Division of Vital Records, P.O. Box 6876i the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phy upletely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier (Check only 1 Certifying Physician:									0/0)	
To the Hos within 24 h To the Fur	Medical		the basis of exam d manner stated.	mation ar	iu/oi investigati			at the time, date				
	2	29b. Signature and title of certifier	11 /	1/		29c. Licens			29d. Date signe		y, rear)	
		40	VIL	6		O.C.	IVI.⊏.		November	15, 2009		
2		30. Name and address of person who com		,		n Ctrant D-1	timore MD 0	1201				
			ief Medical Ex			n Street, Bal	timore, MD 2	1201				
S ⁱ Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar	s Signatur	bark	led .						
Kegis	TELL	WILL FALLE	V. Harling	c. Sid.	Matter that and							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01:35 AM Christine Tokie Turner NOVEM BER 13 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 8, Date of Birth Months Days Hours Min. 0 c t 4, 1946 5. Social Security Number 6 Sex 7 Age (In vrs last hirthday) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F MaryTand 63 218-46-8784 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Baltimore 10e, Street and Number 10g. Citizen of What Country? 21229 USA 22 S. Athol Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: black 3 ☐ Widowed 4 💢 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $1\dot{2}$ nursing assistant healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Brown Nathaniel Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Raltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) 1817 N. Fulton Avenue Baltimore, MD Lisa M. Turner/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5★Other (Spacify) in state 21. Signature of Funeral Service Ronal of icensee Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or continuous resulting in death) ENCEPHAZO PARIT ANOXIC Due to (or as a consequence of): MYGESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): KENAL Due to (or as a consequence of): DISEASE "ORON ART AMERY 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? NELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2☐No 24a. Was an autopsy 1 ☐Yes 2 ☐No . Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

show

Director

Funeral

Completed by

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examiner must be a cultified at

Baltimore, Maryland 21215-0036

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Division

s been signed by tl should be detach e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica

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23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBSTRUCTIVE 25. Was cas examine 1 ☐ Yes 27. Manner 28d. Describe how injury occurred 1 Nati

examiner?			26
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA	Other:
Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		Injury at Work?
2 ☐ Accident investigation		M	1 □Yes

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check onl
	one)

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

out TE

29b.	Signa	ture	and	title	of	certifi	er
	1	-	~		_		

ATTENDING

DO056948

PLACE

NOV 2009

BATIMONE MD 21201

1AMILMAN 31. Date filed (Month Day. 1 9 2009

300 ARMON)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the I

State Registrar 31. Date filed (Month, Day, Year) NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Saluja MO cet

MO

and manner stated.

3612 falls Rd Balt MD 21211

29c. License number

D0054056

29d. Date signed (Month, Day, Year)

To the

09-08633 Roylin G. Webb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cer	tificate c	of Death	and mone	ar r rygionio	Reg. No.	2009 371
Physic Medical Exam	ian/ ine	Decedent's Name (First, Midd Roylin	de,Last) George		Webb			2. Date of De Month	eath Day Yea er 2, 2009	3. Time of Death 1714 hrs
		4a. Facility Name (if not instituti				4b. City, Town	, or Location of		4c. County	
∕ Funeral		Sinai Hospital 5. Social Security Number	6. Sex 7. Aq	- () 1		Baltimor			N/A	
Director		212-92-7844	1X M 2 F	62	ast birthday) Yr		Year If Under: Days Hours		3/1947	9. Birthplace (State or Foreign Country) Jamaica
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion				10d. Inside City Limits
daryland 28a-f show	 5	MD N/A		В	altim	ore				1 X Yes 2 No
1 the Maryland 3a or 28a-f sho otified at once	Director	10e. Street and Number				10f. Zip Coo			10g. Citizen of Wh	nat Country?
vith the s 23a o e notifi		3131 Virgin	ia Avenue	Francia III	2 140 141	212			U.S.A.	
death v r item	Funeral		larried Armed Forces?		5. 13. W	as Decedent of Yes, specify Cu	Hispanic Origin Iban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Race White	- American Indian, Black, e, etc.
215-0036 be filed within 72 hours after death with the Maryland mal Hygiers than "natural", or items 23a or 28a-f she ent, the Melical Examiner must be notified at once	þ		vorced If Yes, Give Year			Yes 2 X			Specify:	Black
2 hour "natu I Exan	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Deceder during m	nt's Usual Occi nost of working	ipation (Give kin life. DO NOT us	d of work done e retired)	16b. Kind of Bu	siness/Industry
5-0036 led within 7 Hygiene. other than	Completed	6th Grade		,	Auto	Mecha	nic		unkno	wn
21215-003 uld be filed withi Mental Hygiene. marked other it		17. Father's Name (First, Middle	, Last)				18.Mother's I	Name (First, Middle	, Maiden Surname)	mn-unknown
Z = 2 = 3	To Be	unknown 19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	a Address (S	Iris	er or Rural Route N	Imber City or Town	n, State, Zip Code)
E g p g g s) (2 a) (2		(friend)		313	1 Virg	inia A	ve., Ba	lto., M	D 21215
Baltimore, ML bernit, Pages I and 2 s Department of Health at Important: If item 27		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from Sta			sition (Name of her place) Brown	_ /	Date	ŀ	City or Town, State
ltimo it. Pag rtment priant: y or ot		4 Donation 5 Other Sp. 21. Signature of Funeral Service	pecify:	100	d Cre	matory	<u> </u>	1/14/09	Balti	more, MD
Balti permit. Departm Imports injury o		21. Signature di Funeral Service	Licensee W. Will	lian	no 122.1	Name and Addi PSEPh	ress of Facility H., Bro	wn Jr.	Funeral	Home ore,MD21217
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused on each line	the death. I	Do not enter t	he mode of dyi	ng, such as card	diac or respiratory a	rest, shock, or hea	art Approximate Interval
/Medical 'xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic (ease				Between Onset and Death
		Sequentially list conditions,	Due to (or as a conse b.	quence of)	:					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of)	:					
\$ g &	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
execute an and	edical	UNPENDED	d							
760, icate be executed physician and the burial - transit	Σ	IF FEMALE:	23c. If ves. outcom	e of preans	ancv				23d. Date of	dolivos
certific		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at t		2 Fe		3 Ectopic pr	regnancy	Month	Day Year
O. Box 687 at the death certifi d by the attending	Physicia		nown g Unknown		3 00	her (Specify)				
that the ned by detach	by P	Part II. Other significant conditi	ons contributing to death	but not res	sulting in the u	inderlying caus	e given in Part I			oute to the cause of death?
ords, P.C. w requires that is been signed to should be deta								1Ye		Probably 4 V Unknown
Records, The law require ficate has been si, page 2 should b	Completed							auto	psy pr	/ere autopsy findings available rior to completion of cause of eath?
tal Recian: The		25. Was case referred to medical				26 Pis	ace of Death (Ch	1 ✔ Yes		✓ Yes 2 No
of Vital ng Physician: Utter this certif	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatien	t 2 🗸 E	R/Outpatient		Other:	ursing Home 5	Residence 6	Other:
tending Physician: The law requires that the death certificate be executed teath. for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi		27. Manner of Death 1 Natural 5 Pend		y ar)	28b. Time of Ir	_	njury at Work?	1	how injury occurre	d
<u>.o</u> < 2 5 5 5	Certification:	3 Suicide 6 Could	inot be mined (Specify)	ıry - At hom	ne, farm, stree	et, factory, offic	e building, etc.	28f. Location or Town,	(Street and Number State)	r or Rural Route Number, City
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in		202 Certifier	ysician: To the best of my	knowledge	. death occur	red at the time	date and place	and due to the cau	se(s) and manner	20 stated
To the within To the comple	Medical	one) 2 Medical Exam	niner: On the basis of exam and manner stated.	ination and	l/or investigat	ion, in my opini	on, death occur	red at the time, date	and place, and du	e to the cause(s)
	≥	29b. Signature and title of certifier		/			nse number			d (Month, Day, Year)
	-	30. Name and address of person	who completed cause of de-	ath (Item 3	8a)		C.M.E.		November 9	, 2009
``		Zabiullah Ali, M.D. A	assistant Medical Exa		111 Peni	n Street, Ba	altimore, MD	21201		
Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Registrar's	Signature	ha	Kal				
	_	1 1 10	/							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aslean 2009 Jean Wilson 10:20p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilcrest Hospice Baltimore N/A5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Months Hours Baltimore, MD 218-82-6867 0294794964 Director 45 Usual Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 XYes 2 No MD N/A Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1033 Bethune Road 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. narked other than 10th Grade College (1-4 or 5+) Cleaning Self Employee Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Allison Wilson Villa Hodges Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2: 4930 Greencrest Road Balto., MD 21206 Annie Fitzgerald (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. Joseph Brown F/H And Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/13/09 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Balto., MD 21217 fart 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Inmediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Jause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performed After this certificate [1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Director filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Name Pranticien: To the basis of my knowledge death occurred at the time, date and due to the cause(s) and in amortis stated (Check within 2 To the F only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sale more, My 2120

State Registrar 31. Date filed (Month, Day,

Year)

2009

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eg trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** NOZ 3:450 M 2009 Mabel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HOSPITAL BAltimore timore (ili R 11 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 1 E 214-26-3276 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town-or Location 10d. Inside Çity Limits 28a-f shov Director 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? 0 "natural", or items 23a Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever'in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White_etc 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than ' College (1-4or 5) Elementary/Secondary (0-12) Ca a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. -daughler Balto md, 21207 909WI FOREST 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ② Other (Specify) 11-30-09 OUINGS MILLS, MD. forest Vet. 21. Signature of Feral Service bicens 22. Name and Address of Facility 270 FredHILTON Sauto, ma. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Heari DireasE **Physician**) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transii Due to (or as a consequence of) O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **Y**No 2 🗖 No 1 ☐ Yes 1 ☐ Yes Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death.

1 Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D005455 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURKE 25 IANIZ MEDERICK

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

as MAbel

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death More If Under 1 Year 9. Birthplace (State or Foreign Country) (arolin **Funeral** 7. Abe (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day Months Min 1 X M 2 □ F Hours **Director** Yrs. Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in ∅.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📈 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father'ş Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) (Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition
1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 11/18/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility IOSEPH L. RUSS 222 W. NOFF Ave. I Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Due to (or as 1 c insequence of): Pnysician/ HEMA TOMA disease or condition 11111 Medical resulting in death) Examiner INKNOW Esquantially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death
Unknown ed by the detached P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rcha discesse Diasetes McHITUS SDivision of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? cerebro vascular 24a. Was an has autopsy After this certificate I Deripheral Vasunder discas, 1 Yes 2 No Be 2 . Was case referred to medical 26. Place of Death (Check only one) iner? examiner? Hospital 2 🗌 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury work? 1 ☐ Yes 2 🐧 No Fall death. UNKNOWN Investigation VNKNOWIM within 24 hours after deat To the Funeral Director: completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined MKNOWN UNKNOWN Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

AARON

31. Date filed (Month, Day,

6701 N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2009

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32. Registrar's S

November 10 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1506 Alice M. Walter /Medical Examiner Town; or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth (Month, Day, Year)
May 8, 1937 Age (In yrs. last birthday) **Funeral** 1□M 27 F Months Days Hours 216-34-1499 72 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, it e Modical Experient must be notified at Director 1 ☐ Yes 2√ No MD Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 923 Francis Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite minortant or other traumatte event, it a Monfied Experimenty injury or other traumatte event, it a Monfied Experimenty injury or other traumatte event, it as Monfied Experiment. 1 ☐ Yes 2 X☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🗓 No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) own home housewife 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Winfield Zais Mary Celeste Nestor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Walter Sr/spouse 923 Francis Avenue Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euner 1 St. wade. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca Le (Final disease or condiresulting in death) Physician /Medical Arrythmin Pardicic 2 minutes Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably A Unknown is certificate has been si I director, page 2 should I Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy perform 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 1 Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To 27 Mapner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 5 Pending investigation Within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Box 68760

P.O.

Division

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Avenue Baltimore,

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MD 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

BL9916791

November 14, 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joyce Marlene Alderson 11:45 a M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4912 Riverdale Road Riverdale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min Director 577-38-3349 78 Washington, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Prince George's Riverdale 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral with 4912 Riverdale Road 20737 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates and Mental Hygiene.
is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Operations Actuarial Statistics 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Kenneth Gene Unzicker Helen Branz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Jeffrey L. Alderson / Son 1640 Coquina Drive, Merritt Island, FL 32952 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 11/9/2009 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA slar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1/2 years Immediate Cause (Final Ph_sician/ Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 X No Year Pregnant at time of death 5 Other (specify) Month Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No this certificate 1 ☐ Yes 2 ☒ No After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🛛 Natural 5 Pending injury e Hospins.
In 24 hours after death.
he Funeral Director: Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifie only one) 29c. License number 29d. Date signed (Month, Day, Year) 145014 NOVERBLY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella C. Martire, MD, 8343 Cherry Lane, Laurel, MD 20707

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ November Day 2009 Maurice Van Gundy Anchor 8:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham 6. Sex 1 M 2 □ F Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 77 Feb. Pay, 1932° Director Washington DC 579-40-9442 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's College Park Maryland 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9746 Wichita Avenue 20740 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 Divorced 1954 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7£h Painter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ൧ Corrinna Freed pe. Martin Anchor 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7918 Delmont Station Road, Severn MD 21144 Donna Ferrari (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Riverview Cemetery 11/6/2009 Waynesboro, Virginia 21. Signature of Funeral Service Lifense 22. Name and Address of Facility McDow Funeral Home aumore 1701 W. Main Street, Waynesboro, VA 22980 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Stage IV Lung Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Malignant pleural effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): law requires that the death certificate be executed Left leg deep venous thrombosis Cause (Disease or liniury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Diabetis mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe (1 X Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No Hospital or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3No မှ 1 Yes 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending work?
1 Yes 2 No To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completed filled in by the ft death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Franklinian: To the basis of my horneage, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 November 2, 2009 2 D0062116 2

State Registrar 32. Registrar's Signature

7705 Belle Point Drive, Greenbelt MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meklit Workneh, M.D.

NOV 0 5 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland Peres	/ Department of Health and r me, g897,11/19709dhb Certificate of Death	Mental Hygie	2009 37123									
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death									
	Physici /Medic	al	JOSEPHINE BROGDEN		October .	14, 2009 07:50 ^M									
	Examin	er	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital	4b. City, Town, or Location of Dea	atri	4c. County of Death Montomgery									
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hr		Birthplace (State or Foreign									
и	Director		216-38-6567 ^{1□ M 2} X F 98	Yrs. Months Days Hours Mir	n. (Month, Day, Y 4/11/11	(ear) Country) VA									
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City.	Town or Location		10d. Inside City Limits									
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	r 28a	Director	MD Montgomery Silve 10e. Street and Number	er Spring 10f. Zip Code	10g	, Citizen of What Country?									
	th with		3213 Norbeck Road	20906	1	USA									
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Everi in a must be neillied at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.									
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√€ No If Yes, Give Ye ar or Dates:	1 □Yes 2 XNo Specify:		Specify:									
21215-0036	2 hour		15. Decedent's Education	16a. Decedent's Usual Occupation	16	Black b. Kind of Business/Industry									
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21	ad wit ygien er th:	Con	6	Domestic		Home									
Maryland	be fill ntal H ed otf	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	iden Surname)									
Σğ	hould d Mei marke	ပ	David Jarrett 19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or F		City or Town State Tip Code									
	nd 2 salth an 27 is i		Clifton Lee - nephew	PO Box 191, Sandy Sp.											
altimore,	es 1 and 2 and Property of Health a Fitem 27 is rother trau		Z ·	ce of Disposition (Name of metery, crematory or other place)	Date 20	c. Location - City or Town, State									
Ĕ	Pages ment of I ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.	Zion Church Cem 10,		rookeville, MD									
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedcal Eventine must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility S											
	102 0 0		23a Part 1 Enter the discussion or complications that caused the death	246 N. Washington											
e =	Dhysisian	0	shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death Say Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device of the mode of dying, such as cardiac or respiratory arrest, and Death Sex Every device or respiratory arrest, and Death Sex Every device or respiratory arrest											
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/ita	ysician; The is certificate hidirector, page	Be	25. Was case referred to medical examiner?		eath (Check only one)										
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Division of Vital Records,	ding Phy h. After thi funeral	tion	Found, Day, Year)	8b. Time of 28c. Injury at Work? 1 □ Yes 2 ▼No	Probable										
<u>isi</u>	I or Attendafter death	fica	3 Suicide 6 Could not be determined determined		28f. Location (Street	et and Number or Rural Route Number									
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl and manner stated.	edge, death occurred at the time, date and pla on and/or investigation, in my opinion, death oc	ce, and due to the cau curred at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)									
_	vithii Comp	ž	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)									
			· (Wellovenz)	41854		10/22/09									
			30. Name and address of person who completed cause of death (Item 2	13a) (Type, Print) 101 Pince Puilix	o Dr. C	Then HD 20832.									
	Sta		31. Date filed (Month, Day, Year) 32. Jegistrar's Signatur												
	Registra	ar	UCT 23 2009 Brus B	galla.											

09-08460 Robert Burdette Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director			5. Sex 1 X M 2 F	7. Age (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. 8 Min.			I C	ountry)	ington D	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Mar	ried Armed F	ecedent Ever in U.S Forces? 2 No $^{\rm par}6/59-12$	If Ye	es, specify	Cuban,	Mexican, I	n r (Spec Puerto Ri	ify Yes or N can, etc.)	40-	White, etc.	√hite		
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Box (e death ce the attented for use	ysici	1 Yes 2 No 9 Uni	, =	gnant at time of de known	^{eatri} 5 O	ther (Spec	cify)								Y
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Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been s tely tilled in by the funeral director, page 2 should	Certification: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Da	ate of Injury onth, Day, Year) , 2009	28b. Time of 0230 hrs		28c. Inju	ry at Work	k?	28d. Descr	ibe hov	w injury occurred ito collision			
Division ospital or Attendia hours after death. Internal Director: y filled in by the fi	rtificati	2 Accident Inve 3 Suicide 6 Cou	stigation 28e. P	lace of Injury - At h			, office b	ouilding, e	tc.	28f. Location or Tow Route 4 S	on (Strong) vn, Stat	eet and Number of te) Diummer Lar	r Rural F	Route Number, C	ity
To the Hospital within 24 hours To the Funeral completely filler		29a. Certifier (Check only one) 2 Medical Exa	huslains. To the	bact of my knowled	dge death occi	urred at the	time, d	ate and pl	ace, and	due to the	cause(s) and manner as	stated.		
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		Onute					O.C.	M.E.				November 1,	2009		
Rainil		30. Name and address of person Ana Rubio MD. As	who completed o		m 23a) 111 Penn	Street. F	Baltim	ore, MD	21201	1					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 30, 2009 DOROTHY MARIE CONNELY 07:28 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Month, Day, Ye TEXAS Director 91 464-34-8117 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No ANNAPOLIS MARYLAND ANNE ARUNDEL 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 930 BAY FOREST COURT, #326 21403 UNITED STATES items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 TEACHER PUBLIC EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or net to the state of the sta မ CLYDE WILLIAM STEPHENS PEARL PARISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELECTRA BYUS/DAUGHTER 128 SPRING PLACE WAY, ANNAPOLIS, MARYLAND 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State NOVEMBER 2, 2009 STEVENSVILLE, MARYLAND 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 4 Donation 5 Other (Specify) CENTER 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Lig Will Elon M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardionyona disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): sician a burial-t Physician/Medical Box 68760 phys the attending p IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death by the a Unknown 9 Unknown P.O. I ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate | 2 No 1 Yes ☐ Yes
 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural To the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 45 D61829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Re I, MA nalde ffled (Month, Day, Year) State NOV 03 Registrar

		_ For	Please	State of Ma						ital Hy	giene	е	07106			
	_	 State Registrar 				Cer	tificate of	Death				2009	3/126			
Physicia /Medica	_	1. Decedent's Nam	e (First, Middle, L orge Cald	ĺ					L	Date of De Month vembe		2009 Year	3. Time of Death 1:00 A ^M			
Examine			-	ive street and number) Boulevard			4b. City, Town, o				40	County of Deal	_			
Funeral		5. Social Security N		Sex 7. Ag		ıst birthday)	If Under 1 Year	If Under 2		Date of Bir			thplace (State or Foreign ountry)			
Director		036-22-79		1 ☆ M 2□F	75	Yrs.	Months Days	Hours	Min Feb	ruary	^y 26'	,1934 S	hanghai			
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e Mari	Director	Maryland	Freder	ick	Wal	kersvi						1€2√es 2 □ No				
with th	al Dire	10e. Street and Nu 8435 Dis		oulevard			10f. Zip Code 21793				_	itizen of What Co USA	ountry?			
tems 2	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	If Yes, specify Cuban, Mexican, Puerto			gin? (Specify , Puerto Rica	Yes or No in, etc.)	-		ce - American Indian,				
irs afte	र्व	1 ☐ Never Marr 3 ☐ Widowed	ied 2 🙀 Married 4 ☐ Divorced	1 ∰Yes 2 ☐ If Yes, Give Year or Dates:	No	1	I∐Yes 2 ⊠ No	Specify:				Specify: W	hite			
72 hou natura lical E	Completed	(Spec	15. Decedent's l cify only highest g	Education rade completed)	Ţ	16a. Deced	dent's Usual Occup	ation during most	of working	Ì	16b. F	Kind of Business	'Industry			
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e filed of the state of the sta	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surm															
Menta Menta arked atic ev	James Edward Caldwell rauta Filipova															
and 2 sho ealth and 27 Is m er traum		19a. Informant's N Nancy Ca	lame/Relationship 11dwe11 -	(Type. Print) • wife			g Address (Street Discove					rsville.	Zip Code) Maryland 793			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depa trinent of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rudflind at once.			•	Removal from State	ce	metery, cren	sition (Name of natory or other place Cremator	y 1	Date .1/03/2	2009		ocation - City or	Town, State Maryland			
pa tm. F portar y i jur	1	21. Signature of Fi				22	. Name and Addre	ess of Facility	Sta	uffer	Fu	neral Ho	оше			
9 a m e 6		(Cum	Jelle (Vine_			21 Oposs					ick, Mar	-			
		23a. Part 1. Enter t shock, or hea Immediate Cause	art failure. List onl	mplications that caused y one cause on each li	ne.					-			Approximate Interval Between Onset and Death			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Burnchu quaic Cancu The Curys Due to (or as a consequence of):														
Examiner	_	Sequentially list co	enditions,	b												
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
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eath certific attending p for use as t	Physician/Medica	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcome								23d. Date of de	livery			
ne death the atte	sicial	in the past 12 1 □ Yes 2	? months? □ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	СУ				Month	Day Year			
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The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the table.	d by	Chr	mie Ol	Least Least	- lu	n ale	sease			1 🗗	/		robably 4 🗆 Unknown			
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sician: The law certificate has t irector, page 2 s	Be	25. Was case referexaminer?	/	Hospital:			Ott		of Death (C	- 2						
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or Att after d Direct in by i	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determine	d 28e. Place of Inj building, el	jury - At hor ic. <i>(Specify</i>	me, farm, str	eet, factory, office		28f.	Location (City or To	Street a wn, Sta	and Number or R te)	ural Route Number,			
		29a. Certifier (Check only		Physician: To the best aminer: On the basis of	of examinat											
To the within 2 To the comple	Medical	one) 29b. Signature and	title of certifier	and manner st	MD.		29c. Licens	se number			29d. D	ate signed (Mon	th, Day, Year)			
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1041		30. Name and add	taqui	o completed cause of o	non	tela	Print) The Aux	e Fre	ederi	ck,	m	D 21	101			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Ma Registrar	•	artment of Health <i>rtificate of Death</i>		giene Reg. No 2009	37127
	Physicia	an.	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
	Physicia /Medic		LEWIS E	CLARK	T	OCTOBE	R 31,2009	9:05A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	ΛТ	4b. City, Town, or Location FREDERTCK	of Death	4c. County of Deat	
-94E	Funeral		FREDERICK MEMORIAL HOSPIT. 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Unde			hplace (State or Foreign untry)
	Director		214-28-9509 ¹ X M 2 G F	76 Yrs.	Months Days Hours	Min. (Month, Da) May 27		yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryla f sho	Ď	Maryland Frederick					1 □Yes 2X No
	r 28a	Director	10e. Street and Number	rre	derick 10f. Zip Code		10g. Citizen of What Co	untry?
	th with		8094 Wallace Circle		21704		United Sta	tes
	tems ferms	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	origin? (Specify Yes or No- an, Puerto Rican, etc.)		rican Indian,
36	s afte	by F	1 ☐ Never Married 2 ☒ Married 1 页 Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1	D	1 □Yes 2√√ No Specify		Specify: Wh	
Ö	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at		15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/	
215	hin 73 e. an "na Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	kind of work done during mo DO NOT use retired)	st of working		
7	ed wil		12		om Woodworkir		Retail Woo	d Shop
and	ould be fill Mental H arked oth attc even	Be	17. Father's Name (First, Middle, Last)			her's Name (First, Middle,	ŕ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	유	Thomas M. Clark 19a. Informant's Name/Relationship (Type. Print)	19h Maili	Let		Blackwell	
	nd 2 s alth ar 27 Is r trau		Nancy E. Clark / Wife		Wallace Cr./		-	
ře,	item 27		20a. Method of Disposition		osition (Name of matory or other place)	Date	20c. Location - City or	
<u>E</u>	Pages ment of ant: If ite ury or o		1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		i	Nov.3,2009	Frederick,M	larvland
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	2	2. Name and Address of Facil	lity Stauffer	Funeral Hom	e
	<u>~</u> □ = # 0		Baymond Teles		621 Opossumto			
J		2 VZ	23a. Part I. Enger the disease, or complications that caused to shock, a heart failure. List only one cause on each line	Э.		is cardiac or respiratory ai	rrest,	Approximate Interval Between Onset and Death
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K	7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	21.3687			
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60,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a	consequence of):				
68760	ificate be executed g physician and as the burial-transit	edical	d					
Box (n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of				23d. Date of de	ivery
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<u>S</u>	eath. or: At	catic	2 Accident investigation	,,	M 1□Yes 2□	□No		
\leq	after death after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, office	28f. Location (8 City or Tov	Street and Number or Ri vn, State)	ural Route Number,
ш	To the Hospital or Attending Physician: within 24 hours after death. Ot the Funeral Director: After this certifics completely filled in by the funeral director, r		29a. Certifier 1 CertifyIng Physician: To the best o	f mv knowledge, deal	th occurred at the time, date a	and place, and due to the	cause(s) and manner a	s stated.
	te Hos n 24 h le Fur pletely	edical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or it	nvestigation, in my opinion, de	eath occurred at the time,	date and place, and due	to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
			Ind a Olly & u	0	04190	44	11/2/0	9
1	041		30. Name and address of person who completed cause of de Gerard A DelGrippo Jr. M.P.	ath (Item 23a) (Type,	Print)	n = I	la vII na.	2 2 /2 -)
1	Sta	to	31. Date filed (Month, Day, Year) 32. Registral	CES 1400	was Juneson	W. L 110c	write it pil	617.4
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 31, 2009 Faye A. Corum 7:33 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 212-68-9947 1 M 2 CK Director June 4, 1956 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "red Exercited Item 1, and the method and prince. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1—Yes 2 ☐ No Director Maryland Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 Motter Avenue, Apt. 45 21702 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dietary worker Food service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Corum Garnetta Tice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Riley - sister 10825 Pleasant Walk Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🚾 Cremation 3 ☐ Removal from State Stauffer Crematory 11/05/2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Myocardial metin Minutes disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an iis certificate has director, page 2 a autonsy perform 1 ☐ Yes 1 □Yes 2 No 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carid

NOV

, MO

32. Registrar's Signature

(Roseras)

10

backs

801

29c. License number

D43091

TOLL House Ave.

29d. Date signed (Month, Day, Year)

11-2-09

37129

	-	For State Registrar		Siai	e or ivi	aryıan		tificate			nentai Hy	gieni Reg. No		7	3/12/
Physician		1. Decedent's Name	e (First, Midd	le, Last)							2. Date of De	ath Da	ay Y	ear	3. Time of Death
/Medica	_	Mary		ise		augh					Octobe	r 31	, 200	9	4:55 P ^M
Examine		4a. Facility Name (/ 15021 Qu								ation of Death			County of		
Funeral	-	5. Social Security N		6. Sex		ne (In vrs.)	last birthday)	Sabil If Under 1 Y		IIIE Inder 24 Hrs.	8. Date of Bir	rth	reder		lace (State or Foreign
Director		219-46-11 Usual Residence of		1□ M 2₺		64	Yrs.	Months Da	ays Ho	ours Min.	July 2	av. Year.)	Coun	yland
yland now	Ì	10a. State	10b. County			10c. City	y, Town or Lo	cation			10d. Inside City Limits				
ith the Maryland or 28a-f show	2	Maryland	Frede	rick		Sal	oillas	ville							1 □Yes 2x No
or 28	5	10e. Street and Nur	nber					10f. Zip Co	de			10g. Ci	itizen of Wha	at Coun	try?
eath with	8	15021 Qu	irauk	School	Road			2178					USA		
or iten	2	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ried Arme	Decedent ed Forces? ∕es 2 ⊡ s, Give or Dates:			Vas Decedent fYes, specify (I □Yes 2 🔀		nic Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	White, e	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Expones.	biele	(Special Second	ify only highe	nt's Education est grade comple Colle	ted) ge (1-4or :	5+)	16a. Deced (Give life. L	lent's Usual O kind of work do OO NOT use re	ccupation one during tired)	g most of work	ing	16b. k	Kind of Busin	ness/Inc	lustry
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d Mer narke natic	2 -	Robert 19a. Informant's Na	/D. I. I.	Hunter		McAfe				Nora		eLau			
and 2 sl salth an 27 Is I er traui		Robert L.					1	-			al Route Numb L Road,				Le, MD 2178
ges 1 s nt of He If item or oth		20a. Method of Disp 1 X Burial 2 I		3 ☐ Removal i	rom State	1		sition (Name on natory or other			Date	20c. L	ocation - Ci	ty or To	wn, State
it. Pa irtmer irtant: njury	-	4 ☐ Donation		• • • • • • • • • • • • • • • • • • • •		Mt.N		Ch. Ce		-			ville		
Depg Impo any i		21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Part. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												•	
Physician		Immediate Cause (Fina!	/1	hat caused on each li	the death ne.	Do not ente	er the mode of	dying, su	ch as cardiac	or respiratory a ムナ	rrest,	-		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		b. Du	e to (or as	a consequ				7//					·
executed an and fal-transit		Sequentially list conditions, it is in a data cause. Enter Underlying Cause (Disease or injury that initiated events c.													
rificate be executed of physician and as the burial-transit	resulting in death) Last Due to (or as a consequence of):							<u>-</u>				+			
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		IF FEMALE:		1					T0.7			- 1			0.00000000
To the Hospital or Attending Physician: The law requires that the death cenwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/Medical Certification:) alcum	23b. Was decedent in the past 12- 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 4	Live birth	of pregna 2 Fetal at time of d	death 3	Ectopic pregr Other (specif					23d. Date of Month		ery Day Year
w requires that s been signed t should be deta	5	Part II. Other signif	cant conditi	ons contributing	to death b	ut not resu	llting in the un	derlying cause	given in I	Part I.		obacco Yes 2	1		ne cause of death?
ding Physician: The law requir After this certificate has been s funeral director, page 2 should											24a. Was auto perfo 1 □ Yes		prio dea	or to cor ith?	psy findings available inpletion of cause of
ician: Sertific Sector,		25. Was case referr examiner?	ed to medica							Place of Deat	h (Check only o	-			
this aldir	+	1 ☐ Yes 2 ☐ 27. Manner of Death		· -	1 Inpation		ER/Outpatien	1 3 DOA			me 5 Resi			(Specif)	()
ding th. After funer		1 V (Natural 2 □ Accident	5 Pendir	g (Month, Da	y, Year)	28b. Time of Injury	'	njury at Vork? 1 □Yes	- 1	28d. Describe	now inju	iry occurred		
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this of the Funeral director is the funeral director in Medical Certification. To		3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	not be 28e. F	Place of Injouilding, et	ury - At hoi c. <i>(Specify</i>	me, farm, stre	et, factory, off			28f. Location (City or To	Street a wn, Stat	nd Number e)	or Rura	l Route Number,
o the Hospit ithin 24 hour o the Funera ompletely fille		29a. Certifier (Check only one)	1 以 Certifyir 2 ☐ Med ical	ng Physician: T Examiner: On and	the best the basis of manner st	of examinat	wledge, death ion and/or inv	occurred at the	ne time, da ny opinion	ate and place, n, death occur	and due to the red at the time,	cause(: date an	s) and manr nd place, and	ner as s d due to	tated. the cause(s)
within 2 To the comple	1	29b. Signature and	title of certifie					29c. Lic	ense num	nber		29 d. Da	ate signed (/	Month, i	Day, Year)
		1	7	16	.20			Do	0351	152		1	130	9	
V D		, -	jaNTL	who completed	cause of c	leath (Item	23a) (Type, F	Print) 5/	72	unmer	, mo	21	788		
State Registrar		31. Date filed (Mont	h, Day, Year)	0 3 200	Registr	ars Signat	ure A.	Spark	1						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	ertificate of Death		. No 2009	37130		
ı	Physici	ian	Decedent's Name (First, Middle, Last) Donald William Cleveland		2. Date of Death Month	Day Year	3. Time of Death		
- mark	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October 3	4c. County of Death	20 40 hts		
المرس		Ŷ.	Kline Hospice House	Mt. Airy		Frederic			
	Funeral Director		5. Social Security Number 389-28-1970 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cour	place (State or Foreign htry) sconsin		
	aryland show		10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits		
	the Maryla 28a-f shor	ecto	Maryland Frederick Knoxv				1 ☐ Yes 2 No		
	ath with t	ral Dir	3755 MaplecrestDrive	10f. Zip Code 21758	U	g. Citizen of What Coun	try?		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, I'm Medicel Evarring must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 11 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e			
15-6	"natu	letec	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/Ind	lustry		
212	y withir giene. r than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	pairman		ating and	Air condition		
pu	tal Hyg d othe	To Be C	17. Father's Name (First, Middle, Last)	1	e (First, Middle, Ma	_	- 1		
Maryland	d Men marke	2	William Cleveland		Brandon				
Ma	nd 2 si alth an 27 Is i			•	ress (Street and Number or Rural Route Number, City or Town, State, Iplecrest Drive, Knoxville, Mary				
Baltimore,	Pages 1 and ont of He cut. If item Int. or othe Int.			matory or other place)		c. Location - City or To			
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 2	2 Name and Address of Essility	auffer Fu	neral Home			
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events C.		t,	Approximate Interval Between Onset and Death Y Carl			
Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3		23d. Date of delive	*			
P.O.	that the desined by the and detached for	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year		
Records,	w requires that been signed should be de	þ	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did toba	cco use contribute to the 2 ☐ No 3 ☐ Prob			
al Reco	: The law r cate has be page 2 sh.	Completed			24a. Was an autopsy performe 1 □ Yes 2 B	d2 prior to cor death?	psy findings available mpletion of cause of 2 No		
Vital	Physician: The tribic certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Quinatient	Other:	h (Check only one)				
Division of	ath. r: After	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day, Year) 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	ome 5 ☐ Resident 28d. Describe how	ce 6 W Other (Specify injury occurred	1 Hospice		
Divi	tal or Attend rs after death al Director:	Certifi	4 Homicide determined 200. Frace of injury: At norme, farm, st		City or Town, S				
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)		
	To To To To To	M	29b. Signature and title of certifier	29c. License number D Z Z O 3 7	7 29d	Date signed (Month,	Zous		
2	<i>t</i> 1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) NINTH AUG	Bru	rwid 1	10 21716		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 3 2009	pare					

Box 68760. P.O. certificate

Division of Vital Records, After this within 24 hours after death To the Funeral Director: Hospital 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:00PM 3009 JONKEY C 30 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** senter o Hege View Frederick renesi's If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 027-14-855 1 ☐ M 2 💢 F Months Days Hours Min Director 85 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Marital Examination to other traumatic event, the Marital Examination to other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Frederick Frederick Director XXYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21701 700 Toll House Avenue USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 █ No Specify: Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Connolly Elizabeth Shanley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Walmsley - daughter 8228 Glendale Drive, Frederick, Maryland 21702 20c. Location - City or Town, State 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/2009 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home ure of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence f): /Medical Examiner angestive Heart Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Impuary Disease Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No I Director: A 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30/2000 ward 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Naden-Blucher DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 10-31-2009 2:00 A M MAUDE A. CURTIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arcola Health & Rehabilitation Ctr. Silver Spring Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 □XF 100 06-02-1909 Canada 578-05-1282 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations to the remitation and Injury or other traumatic event, I'm Medical Examinations and permit the modified at 1X Yes 2 □ No Director Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 USA 4413 Puller Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11, Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Specify. Ď 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12\text{th}}$ College (1-4or 5+) Buyer Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Collins Charlotte A. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teresa Barnard/friend 4413 Puller Dr., Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11-04-2009 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary Hedgman MO13'74 Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Renal Insufficiency Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. by Physician/Medical the attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

- 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A.No has 1 □ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11-02-2009 D34472 dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Lynne Diggs, MD

NOV 0 A 2009

31. Date filed (Month, Day,

10400 Connecticut Ave., Suite 206, Kensington, MD 20895-3941

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1:15 am 2009 Alisa Lynett Crews rtober Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Medica La Plata If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🛣 F Hours 156-54-2100 03/30/1969 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 XYes 2 No Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 AZU 7923 Barclay Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No 1 □Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Speech Elementary/Secondary (0-12) College (1-4or 5+) School/Education 12 Special Education Pathologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Crews Betty Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Crews Kellam/Mother 1281 Mozart Dr., Virginia Beach, VA 23454 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne Memori: 11/06/2009 | Virginia Beach, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Pan. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (as a consequence of): Polymicro bid pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Metastatio breast Concer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was dase referred to hedica 2 □ No 1 □ Yes 1 ☐ Yes 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

show

or 28a-f

items 23a

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Director

Funeral

Completed

Be

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MD

injury or other traumatic event, the Medical Examinar must be notified at

is marked other than "natural".

permit. Pages 1 and 2:
Department of Health an Important: If item 27 is any injury or other trau

1 and 2 : Health a

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Records,

Division of Vital

burial-trar the as nse φ

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Completed

Be

Certification: To

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

Garrett

that the death certificate be executed and physician Physician/Medical attending ģ signed t has page 2 certificate this After Hospital or Attending ithin 24 hours after death.

the Funeral Director: After propered in by the fun

within 2.

To the F
complet

State Registrar

investigation 6 Could not be determined

> 29c. License number D0069154

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October 31, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dresslan Hastistan MD Plafa, MD

La renue

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ange	ela Guadalu		1- For State Certificate of Death		eq. No. 21	100 3713
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea		3. Time of Death
Med	lical Exami		Angela Guadalupe Contreras	Novembe	r 5, 2009	0853 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Prince Georges Hospital Center Cheverly	ath	4c. County of D	
	Euroral		,	Irs. 8. Date of Bi). Birthplace (State or
	Funeral Director		, , , , , , , , , , , , , , , , , , ,	lin	6, 2009 F	oreignWashington, Country) DC
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
1	* .		Maryland Prince George's Lanham			1 Yes 2 X No
n	daryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
0	the M a or 2		6860 Riverdale Road, Apt. #104 20706		USA	
1	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		o- 14. Race - A White, e	American Indian, Black, etc.
	er dea'		3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No specify: M	exican	Specify:	Hispanic
	urs afi tural' amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	of work done	16b. Kind of Busin	ness/Industry
	6 72 ho an "na cal Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use n	etirea)	Never W	lorked
	within jiene.	Completed	Infant Infant Never Worked	me (First Middle	Maiden Surname)	orked
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Tatlet o'Hart Wilder, Easty	a Contre		
	212 ould be Ment mark ic ever		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route Nu	imber, City or Town,	
	MD 2 should be a s		Zorayda Contreras / Mother 6860 Riverdale Road			
	of Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ity or Town, State
	Baltimore, permit. Pages I an Department of He. Important: If ite		4 Donation 5 Other Specify: Gate of Heaven Cemetery 11	/10/2009		pring, Maryland
	Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral H	ome,P.A.	4739 Balt Hyattsvil	imore Avenue 1e, MD 20781
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.	c or respiratory a	rrest, shock, or heart	Between Unset and
	Medical kaminer		Immediate Cause (Final disease or condition resulting in death) a. Bronchopneumonia Due to (or as a consequence of):			Death
			Sequentially list conditions, b.			
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	ted 	Examiner	(Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	certificate be executed and physician and see as the burial - transit	dical	X UNPENDED AMENDED 22 27		<u></u>	
	760, cate be physic he bur	<u>o</u>	IF FEMALE: 23a.27.permE. g899 1/15/10 TT 23c. If yes, outcome of pregnancy		23d. Date of d	
	Box 6876 e death certificate the attending phy ied for use as the lied for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy	Month	Day Year
	Box death he atte d for u	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
	Records, P.O. Box 6876 The law requires that the death certificate icate has been signed by the attending phypage 2 should be detached for use as the l	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death?
	S, P uires tl n signe Id be d			24a. Wa		Probably 4 Unknown ere autopsy findings available
	of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	Completed		aut	opsy pri	ior to completion of cause of eath?
	Rec The la icate h	Com		1 ✔ Yes		Yes 2 No
	tal lician:	Be (25. Was case referred to medical 26.Place of Death (Che	eck only one) Irsing Home 5	Residence 6	Other:
	of Vi Physical this eral di	₽:	1 V Yes 2 No 28b. Time of Injury 28c. Injury at Work?		e how injury occurre	
	on c	tion	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town		r or Rural Route Number, City
	Spital hours a neral I	Certification:	4 Homicide determined (Specify)	4		
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, one)	and due to the ca	te and place, and du	e to the cause(s)
	⊢ ≽ F S	Re	29b Signature and title of certifier 29c. License number			d (Month, Day, Year)
			Justo Valle Jelk O.C.M.E.		November 6	o, 200 8
A			30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201		
	S Regis	tate				
	Regis	ARE!	101 - 101			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day NOV. 2009 NANNIE CYMEK 12:20 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F Months Days 216-03-6942 95 SEPT. 20,1914 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 156 WINTER HARBOR DRIVE 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE 3 Nidowed 4 Divorced Specify. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) DEPARTMENT MANAGER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLAUDE C. NEW SR. ORA L. FRENCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOUGLAS S. CYMEK/SON 156 WINTER HARBOR DRIVE, OCEAN CITY, MD 21842 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State CREMATORY OF DELMARVA 11/3/09 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final neumonra) on 5 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause Ent Uncountry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Tarker 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

Physician /Medical Examiner

Department of Health a Important: If item 27 is any Injury or other trains once.

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be notified at

Pages 1 and 2 should be filed v nent of Health and Mental Hygir ant: If item 27 is marked other

with the Maryland

21215-0036

Maryland

Baltimore,

216-03-694

/Medical

Director

Funeral

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Completed

Be

2

Examiner Physician/Medical

use for 1 signed by page 2 should this certificate director,

þ

Completed

Be

မှ

Certification:

Medical

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

Box 68760 P.O. Records, Vital Hospital or Attending Physician: 24 hours after death. Division of

wek, Nanne within 24 hours after death

To the Funeral Director:
completely filled in by the the

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

1 ☐ Yes

2 □No

29d. Date signed (Month, Day, Year)

Franck Island, De 19944

28f. Location (Street and Number or Rural Route Number, City or Town, State)

address of person who completed cause of death (Item 23a) (Type, Print) 1209 Ceres

investigation

6 Could not be determined

Registrar's Signature ulled

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 12 2009 NOVEMBER 11:15p^M EDITH Μ. CLARK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Nursing & Rehab Kent Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | 7 Une 18 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2**)** € F Maryland 96 June 1913 214-30-9178 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examination in the notified at 1 Ves 2 No Director MD Kent Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 872 Washington Ave. 21620 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No White Specify: à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Hurd ၉ Sallie Leathrum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 23242 Handy Point Rd. Chestertown, MD 21620 and Disnosition (Name of Dis William A. Clark (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery 11/16/09 | Chestertown, MD. 21. Sign and Faceral Service License 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 23a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Trac if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 ☐ Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 10 as 2 Y No 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

certificate director, this funeral After t after death Director: filled in by within 24 hours a To the Funeral C

Hospital or Attending

29a, Certifier (Check only one)

29b. Signature

1 ☐ Yes

27. Manner of Deat

1 Natural 2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifie

do

28a. Date of Injury (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin, Wayne D. M.D. 6602 Church Hill Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

State Registrar

Certification: To

Medical

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

-0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08797 State of Maryland / Department of Health and Mental Hygiene 2009 37137 Gregory P. Cordell 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 13, 2009 0239 hrs **Medical Examiner** Gregory Patrick Cordell 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreian Months Days Hours Min Country) Virginia Director 5, 1960 49 Yrs eb. 223-04-7028 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Stafford Fredericksburg 1 Yes 2 X No VΔ 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. notified at once, Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 22405 USA 90 Chapel Green Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 1 X Yes 2 Yes, Give Year 1979-1985 Specify: White Yes 2 X No specify: 4 X Divorced Widowed δ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Integrys Baltimore, MD 21215-0036 Managing Director Energy Services 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Germaine St. Germain Be William Cordell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 92 Chapel Green Rd., Fredericksburg, VA 22405 Michelle Woolf - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Stonewall 1 X Burial 2 Cremation 3 Removal from State 11/18/09 Manassas, Virginia Department of Important: injury or off Memory Gardens 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Covenant Funeral Service 1310 Courthouse Road, Stafford, MDIYTI VA 22554 Approximate Interval 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical Cocaine intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED the attending physician led for use as the burial -23a,27,28a-f,permE, g898 12/30/09 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Month Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by t be detache contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available has been s 24a Was an prior to completion of cause of autopsy death? performed? 1 V Yes No Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2X No Natural 5 Pending unk unk unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be or Town, State) Suicide determined (Specify) unk Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, Medical

> 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 31. Date filed (Month, Day, Registrer's Signature

and manner stated

29h. Signature and title of certifier

mil

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

State Registrar

29d. Date signed (Month, Day, Year)

November 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>		f Health an		giene Reg. No.	009	37138
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	aath Day	Voce	3. Time of Death
	Physici /Medio		Anita Adalaida Dannally								4:25 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of [Death	4c. (County of Death	1
			Potomac Manor Care			Potoma		Ilea I a a		ntgomer	
	Funeral		5. Social Security Number 6. Se	ox 7.Ag ⊒M2∭2F	e (In yrs. last birthday) OO Yrs.	If Under 1 You Months Da		Min. (Month, Da	ay, Year)	Cou	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		90 Yrs.			Sept.	4, 19	19 New	Jersey
	/land		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Man a-f sh	tor	Maryland Montgomer	TY.	Silver Sp	ring					1 ☐ Yes 2 📉 No
	or 284	Directo	10e. Street and Number			10f. Zip Cod	ie		10g. Citiz	en of What Co	untry?
	23a 23a	al	2604 Parker Avenue	2		20902	2		USA		
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent f Yes, specify (of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	0- 1	 Race - Amer Black, White 	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 I If Yes, Give Year or Dates:	No	1□Yes 2🛚	No Specify:			Specify:	.
3	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or Items 23e or 28e-f show event, Ite Madical Examiner must be notified at	edk	15. Decedent's Ed		16a, Dece	dent's Usual Od	ccupation		16b. Kin	W and of Business/I	hite
را	n "ne	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of work do DO NOT use re	one during most of	f working			,
7.	d with giene or tha	E O	12	College (1-401 S	Homema	ker			Own :	Home	
פ	be filed ital Hygi ed other event, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden S	Su <i>mame)</i>	
<u>a</u>	should band Menti	To	John Fink				Meta E	Bruns			
<u>a</u>	2 should be in and Mental I is marked or raumatic eve	1 3	19a. Informant's Name/Relationship (T	уре, Print)	19b. Mailír	ig Address (Sti	reet and Number o	or Rural Route Numb	er, City or	Town, State, Z	lip Code)
Baltımore, Maryland 21215-0036	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic	1 8	Cathy Wetmiller, d	laughter				Silver Sp			
Ö			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, crer					cation - City or	
E	permit. Page Department of Important: ff any injury or once.		'4 □Donation 5 □ Other (Specify,					11/4/2009			
e E	Department Department		2 Signature of Juneral Service Ligens	2				Molesworth I, Damascu			uneral Home
			23a. Part1 Inter the disease, or comp	dications that daysed						ryrand	20872 Approximate
-	Pnysician /Medical Examiner	ner	if any, leading to immediate cause. Enter Underlying	aGeneral Due to (or as	ized Decona consequence of):	ditioni	ng				Interval Between Onset and Death
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last		Obstructi	ve Pulm	onary Di	sease			
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09/80	certificate be executed adding physician and use as the burial-transit	dicai		d. Deep Ve	in Thrombo	sis Dis	ease of	Lover Ext	realt	У	
O. Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ZNo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregn Other (specify			2	3d. Date of deli Month	very Day Year
J.	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
ecords,	w require: been sig should b							1 🗆	Yes 2□]No 3∏Pro	obably 4 XUnknown
ပ္ပ	s bee	Completed						24a. Was		24b. Were au	topsy findings available
ř	0 5 0	E						— auto perfe 1 ☐ Yes	ormed? 2 X No	death?	completion of cause of
Vital K	i cian : The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only			
01 <	9 S S S	10	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie				ing Home 5 ☐ Res	idence 6	□Other (Spec	cify)
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury		Injury at Work?	28d. Describe	how injury	occurred	
DIVISION	Attendia death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ No		/C++	/ Al C	
≥	or At	Certification:	4 Homicide determined	building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, off	ice		wn, State)	Number or Mu	ral Route Number,
	e Hospital or Atten 24 hours after deat 8 Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Phy	/sician: To the hest	of my knowledge, death	occurred at th	ne time, date and r	place, and due to the	cause(s)	and manner as	stated
	24 hos 24 hos Fun etely	edical			f examination and/or in						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	1 /	Λ	29c. Lic	ense number		29d. Date	signed (Month	h, Day, Year)
			> Kuti	VOI	ho h	7.10n2	0274		Novem	ber 2,	2009
(8		30. Name and address of person who c	completed cause of d	eath (Item 23a) (Type,		<u></u>		-10 v CII		
_		H	Kirti Vohra, MD 7	710 Bradl	ey Bouleva	rd, Bet	hesda, M	aryland	20817		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	park	1				

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 27129

			1 - For State Registrar		Ce	rtificate of	Death	,	Reg. No.	.003	37132
Dhysisian			Decedent's Name (First, Middle,	Last)				2. Date of De	eath	Vaar	3. Time of Death
	Physici /Medic		WENDELL		DRUM	MOND	SR.	OCTOBE	ER 30	20 09	4:30 P M
	Examin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death			ounty of Death	
1			6705 DRYLOG				OL HEIGHT			INCE GE	
	Funeral Director		5. Social Security Number 578-52-4403	6. Sex 1 M 2 □ F 7. Age (I. 70	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di JAN 29	rth a <i>y, Year)</i> 1939	Cou	place (State or Foreign ntry) IINGTON, DC
	pu »		Usual Residence of Decedent	146	o City Taylor and a						10d. Inside City Limits
	aryla shov	<u>_</u>	10a. State 10b. County		c. City, Town or Lo						12 Yes 2 □ No
	he M	Director	MD PRINC	E GEORGE'S	CAPI	TOL HEIG	HTS		10s Citizo	n of What Cou	
	with t	ä	6705 DRYLOG ST	roccr		2074	2		USA	II OI WIIAI COU	nu y :
	eath	era	11. Marital Status	12. Was Decedent Eve	rin II S 13			necify Yes or No		. Race - Ameri	can Indian.
980	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Eveninar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1	If Yes, specify Cub 1 □ Yes 2X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White, pecify:	
21215-0036		Completed	15. Decedent's (Specify only highest	grade completed)	i (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kind	of Business/In	dustry
12	filed within Hygiene. sther than '	l wo	Elementary/Secondary (0-12) 10TH	College (1-4or 5+)		AUTO MECI	,			PRIVAT	E
b	F 5 5	BeC	17. Father's Name (First, Middle, L	ast)	l	TIOTO TIBO	18. Mother's Nam	ne (First, Middle	e, Maiden Su		
<u>la</u>	should be find Mental Find Mental Find Mental Find Marked ot	10 B	HORACE DRUMMO	ND			LILLIE	MAE	CLARK		
Maryland		-	19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	ber, City or T	own, State, Zi	p Code)
	1 and 2 Health a tem 27 is		MARY DRUMMOND	/WIFE	6705	DRYLOG	STREET CA	PITOL E	EIGHT	S,MARYI	AND 20743
ore	8 5 = 0		20a. Method of Disposition 1X Burial 2 □ Cremation		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Loca	tion - City or To	own, State
Ē	Pages ment of ant: If it		4 □ Donation 5 □ Other (Sp		HARMONY	CEMETERY		7/2009			ARYLAND
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service L	icensee	2	2. Name and Addre	ess of Facility J	B. JE			
			23a. Part 1. Enter the disease, or o	complications that caused the	death. Do not en						Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. LARYNGEA Due to (or as a co						-	
	Examiner		1	HYPERTEN							
	77	ner	Sequentially list conditions, if any, bearing to infrincipal cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	According to the second						
	cuted nd ransit	Examiner	that initiated events	c							
30,	certificate be executed ding physician and ise as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	cate by physic the p	Medical		d					-		
	certific ding p		IF FEMALE:	23c. If yes, outcome of p	oregnancy					al Data of Jally	
O. Box	atter for u	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 L 4 Pregnant at tin 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23	d. Date of delive Month	Day Year
٣.	that the dended by the a		Part II. Other significant condition	ns contributing to death but n	ot resulting in the ι	inderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
rds	w requires to been signer should be a	d by						1 🗆	Yes 2□	No ¾ □ Pro	bably 4 🗌 Unknown
Records,	s bee	Completed						24a. Was			opsy findings available
Re	о <u>т</u> о	m o						_ perf	opsy formed?	prior to co death? 1 □ Yes	ompletion of cause of 2 ☑No
Vital	ician: The certificate ector, pag	a l	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		I La res	2 140
f <	ys is	To B	examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 □ DOA Oth	her: 4 Nursing H	lome 5 🔀 Res	sidence 6 [☐Other (Spec	ify)
n of	ng Ph fter th neral	딛	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yo	28b. Time o	of 28c. Inju	iry at rk?	28d. Describe	how injury	occurred	
<u>Si</u>	Attending r death. ector; After by the fune	atic	2 ☐ Accident investiga	ation		M 1□]Yes 2□No				
Division	or Att after de Direct in by I	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		- At home, farm, st Specify)	reet, factory, office			(Street and i own, State)	Number or Rui	ral Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C		Physician: To the best of n examiner: On the basis of examiner stated	amination and/or in						
	To the within To the Complex C	ž	29b. Signature and title of certifier	10		29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
				ver	_	D005	8290	•	NOVEM	BER 2	, 2009
	7		30. Name and address of person v	who completed cause of deat	h (Item 23a) (Type,		-58(10)(0)				
1/2			SURESH K. MUT	TATH M.D. 570	0 SARVIS	AVENUE S	SUITE 200	RIVERD	ALE,MA	ARYLAND	20737
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2009	Registrar's	Signature	,					
			110.00	100.00							

DHMH 17 Rev 1/2001

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)	
CA	2	3
		Re

			State of Maryland / De	ndelible Ink. Ensure All C partment of Health and Men ertificate of Death	tal Hygiene 2 n n c	37140
	Physici: /Medic		1. Decedent's Name (First, Middle, Last) Aleisha L. Dingle	2. D	Reg. No. — 9 9 9 Date of Death Month Day Year TOBER 26 7009	3. Time of Death 5 21 PM
****	Examin Funeral		4a. Facility Name (If not institution, give street and number) Doctors Community Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Lanham 1y) If Under 1 Year If Under 24 Hrs. 8. If Months Days Hours Min. Table 1. If Months Days Months M	4c. County of Dear Prince G Date of Birth Month, Day, Carl n. 8,1969 New	
	Director	tor	113-66-5063 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Prince Georges Lanham	Location	11. 0,1909 1ew	10d. Inside City Limits 1 → Yes 2 → No
	h with the 23a or 28a at be redi	al Director	10e. Street and Number 9337 Worrell Ave.	10f. Zip Code 20706	10g. Citizen of What Co	puntry?
980	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show 'fical Examiner ment by moffled at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 X No Specify: 		
21215-0036	d within 72 ho giene. r than "natur its Medical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) memaker	16b. Kind of Business. Own Hame	/Industry
Maryland	ould be filed Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Cleo Douglas Dingle		st, Middle, Maiden Surname) in Holloway	
, Mar	and 2 sho lealth and m 27 is ma her traum		Anthony Royster (SON) 93	ailing Address (Street and Number or Rural Ro 37 Worrell Ave. Lanha	m, MD 20706	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be prefilled at once.		4 Donation 5 Other (Specify) Chesape	position (Name of rematory or other place) cake Crematory Nov. 06 22. Name and Address of Facility Rendo 9013 Annapolis Rd. La		le, Maryland
	beath certificate be executed attending physician and attending physician and tor use as the burial-transit	ical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not one prock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		spiratory arrest,	Approximate Interval Between Onset and Death 72 cky \$.
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medic		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	olivery Day Year
rds, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death? 'robably 4 ☐ Unknown
tal Records,	ician: The law re certificate has bee ector, page 2 sho	Completed	25. Was case referred to medical		autopsy prior to death? 1 ☐ Yes 2 ☐ No 1 ☐ Ye	
of Vi	Physicia this cert	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Mannar of Death 28a. Date of Injury 28b. Time	tient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Sp.	ecify)
Division of Vital	I or Attending F after death. Director: After d in by the funera	Certification: To	1	y Work? 1 ☐ Yes 2 ☐ No street, factory, office 28f. I	Location (Street and Number or F City or Town, State)	tural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de and manner stated. 1 Medical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred a	at the time, date and place, and du	e to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier Pulsed 29c. License number 20058213 De, Print) 2U50 Annapolis Rd	29d. Date signed (Mon	th, Day, Year)	
R	_3			12150 Annapolis Rd	1 # 308 6-lem	Dale MD 20769
PU	Sta Registr	ar	NOV 0 6 2009 Seven S. Sansture			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-2-2:50 PM 2009 Vaughn Davies Robert Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Berwyn Heights 5612 Seminole Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours (Month, Day, December country) t. Mary's, PA Min. 1 🛛 M 2 🗆 F 200-26-3495 Director 72 Usual Residence of Decedent Show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho itury or other traumatic event, the Medical Examiner must be notified at our or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10a. State Director 1 X Yes 2 No Maryland Prince George's Berwyn Heights 10e, Street and Number 10g. Citizen of What Country? Funeral 20740 USA 5616 Seminole Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) National Security Agency Electrical Engineer Δ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Doris Rippon Edwin J. Davies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5612 Seminole Street, Berwyn Heights, MD 20740 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Bertha A. Davies / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State 11/8/2009 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA RAY RESPO 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Interstitual Pulmonary disease or condition years Medical resulting in death) Due to (or as a consequence of): Examiner See questionly that even this was Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day 5 Other (specify) Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 ER/Outpatient 3 DOA မ 1 Inpatient 2 I this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Curtifying Nurse Practioner: To the best of my knowledge, death oncurs of at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0012015 11-3-2009

State Registrar ours

31. Date filed (Month, Day, Year)

Landover

Cheverly MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6492

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	Department of Health and I Certificate of Death	Mental Hygien	2009 37162	2
			Registrar 1. Decedent's Name (First, Middle, Last)	oonmodio o. Dodin	2. Date of Death	3. Time of Death	
	Physicia /Medic		SAMUEL HOWARD DEVORE			Oay 2009 0630 M	4
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	Cumber lance		Allegany 9. Birthpace (State or Foreig	חני
	Funeral Director		1 N/W 0 T E	Yrs. Months Days Hours Min.	8. Date of Birth 11-15-196	9. Birthplace (State or Foreig Co(intry) MARYLAND	
þ			Usual Residence of Decedent	art earlier		10d. Inside City Limits	
arvla	shov	<u>ه</u>	10a. State 10b. County 10c. City, Town			1 X Yes 2 □ No	
the M	28a-f	rect	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?	
3-0030 72 hours after death with the Maryland	of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, if a Medical Examination matic condition	Funeral Director	14215 GARDNER STREET	21529	U. S	S.A.	
r deat	tems	nner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
OCOO	", or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: WHITE	
2 hou	atura cal E	ted	15. Decedent's Education 16a.	Decedent's Usual Occupation (Give kind of work done during most of work		Kind of Business/Industry	
7 1	ne. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	`life. DO NOT use retired)		TOU WADD	
led w	Hygier her th nt, II		12 L	ABORER 18 Mother's Nam	BR ne (First, Middle, Maide	RICK YARD	
d be f	ked of	To Be	PAUL DAVID DeVORE		RUNTONS DeV		
ary shoul	s mari	1		. Mailing Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip Code)	
and 2	ealth					21529	
ges 1	it of H		1 Problem 2 Li Cremation 3 Li Removal from State Name CA	Disposition (Name of ry, crematory or other place)		Location - City or Town, State SAVAGE, MD	
all III O	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Medical Examinations in the modified an once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	1			
	any per		Hen M Source Moo547	60 W. MAIN ST., F		RAL HOME, P.A. MD 21532	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
	nysician		Immediate Cause (Final disease or condition	enal failure		Onset and Death	
	Medical xaminer		resulting in death) Due to (or a a consequence	ic Heratims		570ars	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):		J/EU/	
ecuted	nd transit	Examiner	that initiated events				
ate be ex	physician and the burial-transit		resulting in death) Last Due to (or as a consequence	of):			
DIVISION OF VITAL RECORDS, F.O. BOX 60/00, forthe Hospital or Attending Physician: The law requires that the death certificate be executed	g phys is the	edical	d				_
th cert	t use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery	
e dea	the at hed fo	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day Year	
that th	ed by detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?	
v requires t	en sign uld be	ed by	COGS 4/0paly		1 □ Yes	2 No 3 Probably 4 Unknow	/n
aw re	as bee 2 sho	Completed	Chronic HARAKHS C	in fechicies	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	le f
The T	cate h page	Com			performed′ 1 □ Yes 2 □	? death?	
VII.	certifi rector,	B	25. Was case referred to medical examiner?	Othor	th (Check only one)		-
2 g	er this	ان 1	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at	ome 5 Hesidence	e 6 ☐Other (Specify) njury occurred	
inding	ath. r: Aft ne fun	atio	2 Accident investigation	njury Work? M 1 □Yes 2 □No			
VIVISION AFTER	fter de Jirecto n by ti	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)	
pital, C	ours a		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.	_
e Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.				
70 tt	Vithi Comp	Me	29b. Signature and fittle of certifier	29c. License number		Date signed (Month, Day, Year)	
			Monny Chrystell.	m 6 35/35		11/16/07 mo	
			30. Name and address of person who completed sause of geath (Item 23a)	1) 917 Colm	- linn	boland mo	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Feb Strar's Signature	8 1 .00	001.0		-
	Registr	rar	NUY I I GUUS Jewen &	. Done			

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 13,2009 3:30A. DTXON JAN L. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Burtonsville Montgomery Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 20, 1956 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 53 578-80-0026 Japan Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Maryland Beltsville Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13232 Greenmount Avenue 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【▼No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James E. Schwartz Ruth Treadway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13232 Greenmount Avenue Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type. Print) Anthony E. Haire, Sr. -P.O.A. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/13/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Breast Cancer vears disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans

attending physician for use as the buria

been signed by the should be detached

s certificate has t irector, page 2 s

death. after death

Director:
d in by the f

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medical ODRS.

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner Completed by Physician/Medical Be

		b. Lulig Metastases		MOHENS						
Examiner	Sequentially list conditions, it is, it is in conditions. Enter Underlying Cause (Disease or injury that initiated events	Date to (or as a consequence of):								
dical Exa	resulting in death) Last	Due to (or as a consequence of):								
Completed by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 23d. Date of Month 2 □ Fetal death 3 □ Ectopic pregnancy Month 5 □ Other (specify)									
ed by Pr	Part II. Other significant conditions of Bipolar Disease	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ Pr	the cause of death?						
Complet			autopsy prior to	itopsy findings availabl completion of cause of 2 XNo						
Be	25. Was case referred to medical	26. Place of Death	(Check only one)							
일	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Hom	e 5 ☐ Residence 6 ☐ Other (Spe	cify)						
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	Bd. Describe how injury occurred							
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Re City or Town, State)	(Street and Number or Rural Route Number, Town, State)						
O	V									

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D65485

29d. Date signed (Month, Day, Year)

November 13, 2009

State Registrar

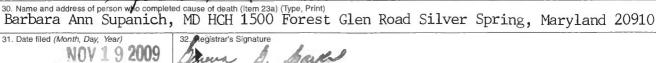
Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

NOV 1 9 2009



and manner stated.



DIC

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			Decedent's Name (First, Middle, L.)		ous , re					2. Date of De	eath		3. Time of Death
	Physici /Medi		GEORGE E		EMSWI	LER				Month Octobe	Day	Year 2009	6:24 PM
No.	Examir		4a. Facility Name (If not institution, g				4b. City, Town,		of Death			nty of Death	
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	Funeral Director		5. Social Security Number 6. 214–32–4997	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bi (Month, D	rth a <i>y, Y</i> ea <i>r)</i> 3 , 1931	9. Birth	nplace (State or Foreign Intry) ginia
			Usual Residence of Decedent						I	Jec. I.	3, 1931	ATT	ginia
	rylan ihow	_	10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	e Ma 8a-f s	Director	Maryland Freder	ick		Mt. A	iry						1 □Yes 2 No
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	s 238	eral	13840 Penn Sho	-	-	3 140		771	1 1-0 (0 -				tates
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 2	s?	5. 13.	Was Decedent of f Yes, specify Cub	pan, Mexica	n, Puerto R	city yes or No Rican, etc.)	D- 14. R B	lack, White	_
036	urs af al'', or Exam	₹	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 □Yes 2 No	Specify.	:		Spec	oify: Wh	ite
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Evantin	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Dece	dent's Usual Occu kind of work done	pation	et of working	a	16b. Kind of	Business/I	ndustry
21	ithin ne.	ם	Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT use retire	ed)		g			
	lled w Hygie ther th		10 17. Father's Name (First, Middle, Las	s4)		Ow	ner / Op	erato		/Final Ministra	Auto , Maiden Surni		Shop
ano	d be f ental i	Be c	William Emswile									ame)	
Maryland	should nd Me mark imati	은	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree	1		Mae B		ın State 7	in Code)
	nd 2 alth a alth a 27 is		Kirk Emswiler			1	Prospect				, Maryl		
ē,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Pl		sition (Name of natory or other pla		Da	ate	20c. Location		
m	Page nent c int; If iry or		1 ☑ Burial 2 ☐ Cremation 3 l 4 ☐ Donation 5 ☐ Other (Spec		ite		e Cemete	· i	Octob 30, 2		Kemnto	wn. M	laryland
Baltimore,	permit. Pages 1 and 2 a Department of Health a Important; If item 27 Is any Injury or other trau		21. Signature o Funeral Service Lice	ensee			. Name and Addr						s, P.A.
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Ь			23a. Part 1. Enter the disease, or cor shock, or heart failur. List onl	mplications that caus y one cause on each	sed the death line.	. Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
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and a	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ience o							
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171	ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events										
o,	ifficate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or	as a consequ	ience of):				<u>-</u>			
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Box	The law requires that the death certi ate has been signed by the attending agge 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?		h 2 🗌 Fetal	death 3	∃Ectopic pregnan	су				Date of deli	very Day Year
0	at the de by the a tached fi	sic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnan 9 ☐ Unknow	it at time of de n	eath 5	Other (specify) _				'	VIOTI(I)	Day Tear
σ.	that the ned by detac		Part II. Other significant conditions	contributing to death	but not resu	Iting in the u	nderlvina cause ai	ven in Part I	l.	23e. Did	tobacco use co	ntribute to	the cause of death?
of Vital Records,	uires n sign ld be	d by					,,			1 🗆	Yes 2 ☐ No	3□ Pro	obably 4 Onknown
00	w requir been s should	Completed								24a. Was	24t) Were au	topsy findings available
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tal		a	25. Was case referred to medical					26 Place	a of Death	(Check only	one)	1 ∐ Yes	2 No
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	ding Ph h. After thi funeral	Ë	27. Manner of Death □□Natural 5 □ Pending	28a. Date of I	njury Day, Year)	28b. Time of Injury	28c. Inju				how injury occ		
Siol	eatle or	atic	2 ☐ Accident investigation	on	23), 70 417	,,		Yes 2	No				
Division	after de after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of	Injury - At hoi etc. <i>(Sp</i> ec <i>ity</i>	me, farm, str	eet, factory, office		28	Bf. Location (City or To	(Street and Nur wn, State)	nber or Ru	ral Route Number,
	pital ours a eral C		29a. Certifier 1 Certifying P	Physician: To the be	et of my know	wlodgo doat	a accurred at the t	time data a	nd place o	and due to the	a course(s) and	monnor on	atatad
	the Hospital hin 24 hours the Euneral In the Funeral Inpletely filled	Medical	(Check only 2 Medical Exa	iminer: On the basis	s of examinat	ion and/or in	vestigation, in my	opinion, dea	ath occurre	d at the time	, date and place	e, and due	to the cause(s)
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by the	Me	29b. Signature and title of certifier		,		29c. Licen	se number			29d. Date sign	ned (Month	, Day, Year)
			> Show	Mospitali	st		B791	740	20		10/23	109	
	1		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Br196 Fredu	- /	4	1. 1	10/00/		
	1		SAFRINA	MASAN	FI	MH	redu	tick,	Man	ykind			

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 Year 1 ff Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🖾 F Yrs. 12/3/1918 578-07-9521 90 Warrenton, VA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show amy Injury or other traumatic event, the Modical Examinating that have nuttled any once. 1X Yes 2 □ No **Funeral Director** MD Prince George's Hyattsville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 5900 33rd Avenue 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 2 Specify: White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Joseph Lunceford Annie Delilah Creel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Early / Husband 5900 33rd Avenue, Hyattsville, MD 20782 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/5/2009 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 helman Leun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INTracerebra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SIFOKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one)

State

within 2.

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

NOV 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

225 Greenest Baltmore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08727 State of Maryland / Department of Health and Mental Hygiene Danny Fisher 2009 37146 1. For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 9, 2009 1952 hrs Medical Examiner Fisher Danny
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Dorchester Cambridge **Dorchester General Hospital** Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Min. Country) Md Director 07-04-1973 1 M 2 Yrs 219-98-9179 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Dorchester Cambridge Md. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 643 Washington Street 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Year Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Hi Tech.Plastics Baltimore, MD 21215-0036 12 ForkLift Driver 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dennis Fisher Glenda Ann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is r r traumatic 108 High St. P.O.Bx54, Cambridge, Md. 21613 Shantae Fisher Wife Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Department of He Important: If it Cem. 1 Burial 2 Cremation 3 Removal from State 11-14-09 Girdletree.Md Cool Spring Church Donation 5 Other Specify 22. Name and Address of Facility Bennie Smith Funer 524 Race St., Cambridge, Me. 216 21. Signature of Funeral Survive Licenses Home Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death /Medical Seizure disorder Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED AMENDED 23a,27,perm,E g897 11/24/09 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✔ No 3 Probably 4 Unknown Þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death Certification: 1 X Natural Yes 2 No Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) within 24 hours a To the Funeral I (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 completely Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific November 10, 2009 O.C.M.E. Mame and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month OF)

DHMH 17 Rev 1/2001 OCME 2006

State Registra

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4630PM FOOTE CLIFTON ctope /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 6. Sex 1 🛣 M 2 🗆 F 8. Date of Birth (Month, Day, Yea SEPT 23 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1927 MARYLAND 220-16-7399 82 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the l'hodicel Extrainer must be indflied at 1. Yes 2 □ No Director PRINCE GEORGE'S BOWIE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13106 8th STREET 20720 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married XYes 2 □ No ARMY If Yes, Give Year or Dates: BLACK 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 7TH HORSE GROOMER If item 27 is marked other or other traumatic event, II Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental MARIA FOOTE CURLEY FOOTE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA FOOTE/DAUGHTER 13106 8TH STREET BOWIE, MARYLAND 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pages Department o Important: If any injury or MD VETERANS CEMETERY 11/9/2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funer Servio icensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1POXIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed nyoni c that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 P.O. Box 68760. physician Physician/Medical 19· the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 5 Other (specify) ed by the a □Yes 2□No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has N autopsy performed page 2**7** No 1 □ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A 2 ☐ Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day State Registrar NOV O R

112 ABETH

FASI BA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck ROAD, LANHAM, MD 20706

MDD60925

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NMOVEMBERS 5, 2009 05:04A M Phyllis M. Grundman Medical 4c. County of Death Haltimore 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Joseph Medical Center 9. Birthplace (State or Foreign Country Mary Land Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours Year 954 1 □ M 2 □ F ABHILL Day 219-60-9446 55 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harkord Havre de Grace 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21078 U.S.A. 250 Revolution Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technician Pharmacu is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ armit. Page 1 and 2 should be 1 spartment of Health and Menta sportant: If item 27 is marked by injury or other traumatic ev Mabel Virginia Meekins John Rosling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Grundman (Husband) Revolution Street. Havre de Grace, Maryland 21018 250 Baltimore, Important If iten any injury or 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) & Co.Inc. 11/6/2009 West Chester. PA 21. Signatural of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. Havre de Grace. Washington Street. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY EMBOLISM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NONSMALL-CELL LUNG CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 LVN Jas page 2 certificate ! 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Funeral Director: After sted filled in by the funer 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending after death. 2 🗌 No 1 Tes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D24034

State

OSLER DRIVE

TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARY FOOTES NOVEMBER 2009 9:30 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year Min. Months Days Hours 1 □ M 2 🗹 F 56 WASHINGTON, DC Director 213-56-9438 Nov. 24 1952 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" — any injury or other traumatic events. 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 ☐ No Director LANDOVER PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20785 2016 RAY LEONARD ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE CARE GIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THELMA BAKER RICHARD FOOTES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2016 RAY LEONARD ROAD LANDOVER, MARYLAND 20785 ARLENETTE FOOTES/DAUGHTER Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND 11/6/2009 RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a constituence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed peral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 A Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury Natural 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lack Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

Registrar

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

		•	For State Registrar	State of Mai	•	Certificate of		R	on No. o. o. o.	27150
	Physici	an	Decedent's Name (First, Middle, La Thomas	ıst)		Farah		2. Date of Deat	r ¹ 38, 200 ⁷ 9 ^{ar}	3.7 mg of beau 5:35 P M
*	/Medio		4a. Facility Name (If not institution, gi	ve street and number)			or Location of Death	n	4c. County of Death	
1			8104 Oxon Hill R		//		shington	8. Date of Birth	Prince Ge	eorge's
	Funeral Director		5. Social Security Number 6. 246–18–8972	Sex 7. Age (1%1⊡XM 2 F	(In yrs. last birth 9	Months Days		Jan. 5,	Year) Coul	h Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	e Mary 3a-f sh	ctor	Maryland Prince	George's	Ft. Was	shington				1 □ Yes 2√√√No
	h with the	al Dìre	10e. Street and Number 8104 Oxon Hill	Road		10f. Zip Code 207	44	1	0g. Citizen of What Coul USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, it is marked by contact must be mailful at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: W		13. Was Decedent of If Yes, specify Cu		pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	
21215-0036	72 hou	eted	15. Decedent's E (Specify only highest g	ducation	16a. [Decedent's Usual Occi Give kind of work done	e during most of wor		16b. Kind of Business/In	dustry
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b	e filed al Hyg other vent, I	BeC	17. Father's Name (First, Middle, Las				18. Mother's Nan	me (First, Middle, I		
ylaı	ould by Menta	2		arah	T		Nazira			
ă N	nd 2 sh Uth and 27 is n r traun		19a. Informant's Name/Relationship Doris E. Farah	1.1		Mailing Address (Stree 04 Oxon Hi			r, City or Town, State, Zi gton, MD	20744
ore,	es 1 and 2 s of Health a of item 27 is rother trau		20a. Method of Disposition	Damaval from State		Disposition (Name of crematory or other pl			20c. Location - City or To	own, State
Baltimore, Maryland	t. Pagr tment tant: I		1 ☑ Krurial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	ify)	Resurr	ection Cem		/2009 (Clinton, Man	ryland
Ba	permi Depar Impor any Ir		21. Signature of Funeral Service Lice	nsee		6160 Oxc	on Hill Ro	eorge P. oad Oxon	Kalas Funer Hill, Maryl	al Home PA and 20745
	Physician /Medical		23a. Par. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the cone cause on each line. a. Due to (or as a cone)	ER O	FTHE	ying, such as cardiac	10	rest,	Approximate Interval Between Onset and Death
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	uted I nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se a	soneaquence of	r				
68760,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):				
89		Medi	IF FEMALE:							
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendir rail director, page 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)	ncy		23d. Date of delive Month	very Day Year
	fuires that the der n signed by the a lid be detached fi	by	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cause o	jiven in Part I.		bacco use contribute to es 2 ズ No 3 ☐ Pro	
Records,	The law requir ate has been s page 2 should	Completed						24a. Was a autops perfor		topsy findings available ompletion of cause of
Vital	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea	ath (Check only or		
	Physer this eral dir	. To	1 Yes 2X No 27. Manner of Death	28a. Date of Injury	28b. Ti	me of 28c. In	4 LI Nursing F		ence 6 Other (Specow injury occurred	ify)
Division of	Attending er death. rector: After by the fune	cation	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not			M 1	□Yes 2□No			
Ω		Certification:	4 Homicide determine		y - At home, farr <i>(Specify)</i>	n, street, factory, office		28f. Location (S City or Tow	treet and Number or Rui rn, State)	al Houte Number,
	Hospi 4 hou Funer tely fil	Medical (Physician: To the best of aminer: On the basis of and manner state	examination and					
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Lice	nse number	- 1	29d. Date signed (Month	, Day, Year)
Ì	12		30. Name and address of person wh	completed cause of dea	ath (Item 23a) (1	ype, Print)	102 17		OVENPER 1F, Ud.	7000
R	√ ^{/ ð}	ite	31. Date filed (Month, Day, Year)	7.0.120	's Signature	DUNEC	autor	WHERE	it, Md.	12601
	Regist		NOV 0 6 2009 /	Eners > B.	's Signature	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** РМ 3Ó 2009 Frink _Anthony 10 Jerome /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**☑** M 2□ F Yrs Director 04/07/1958 Washington, DC 579-84-4382 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County items 23a or 28a-f shor 1 Yes 2 No Director Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20011 USA 939 Longfellow Street, NW Funeral Apt. 3 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 7 is marked other than "natural", or il traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: à 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Cook Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of and 2 should be Leola Woodley ဂ္ Frink, Sr. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. 939 Longfellow St., NW Apt. 3 Washington, DC 20011 <u>Debra Frink / Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lincoln Crematory 11/09/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Dreta rances 3401 Bladensburg Road Brentwood, MD 20722 23a. Prit 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if your List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Idiopathic Interstitial Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): 68760. Physician/Medical attending pl Division of Vital Records, P.O. Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 □ No 4 Pregnant at time of death Day 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Chronic Pancreatitis, Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an Peripheral Arterial Disease, HTN, Failure to Thrive performe certificate 1 □Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 Der ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natura 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral or services. investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/30/2009 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave. Suite 117 Silver Spring, MD 20902 Shyamsundar Rajan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State 5 2009 Backs Registrar MOA U

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 8:20 p M Barakissa Gbane Nov. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)Bondoukou 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕱 F 217-53-1246 Director 1,1974 Jan. Africa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Md. Montgomerv Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6420 Sligo 20912 Mill Rd. Cote D'ivoire Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No ρ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 9 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dabila Gbane 2 Camara Tenin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6420 Sligo Mill Rd. Takoma Park Ma. 20 Date 20c. Location - City or Town, State Md. 20912 Alamissa Ouattara/brother Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Family Cemetery 11/12/09 Cote D'Ivoire 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Ligensee Vicotter 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 411 Kennedy St., NW Washington, DC 20011 Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 In No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kouertcheu, ms 11/5/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 6001 Muncaster Mill Rd. Rockville, Md 31. Date filed (Month, Day, Year) State NOV 0 6 2009 Registrar

DHMH 17 Rev 1/2001

09-08595 John E. Greene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 37153 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2009 0846 hrs Medical Examiner Greene John E. 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 500 N. Luzerne Avenue g. Birthplace (State or If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min Director Baltumore, MD 04-18-1952 212–60–3886 57 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County X Yes 2 No Baltimore is 23a or 28a-f show e notified at once. Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21205 U.S.A. 500 North Luzerne Avenue 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noitems must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married 1 Never Married 2 Yes marked other than "natural", or i c event, the Medical Examiner mu Black Yes 2 X No specify: Specify: 3 X Widowed Yes, Give Year Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours in nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natura or other traumatic event, the Medical Examin 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Technician Public Works 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Calhoun Ida Greene Mae Be Clarence G. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5409 Grindon Ave., Baltimore, Maryland Keith T. Cook - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Riverdale Pk Crematory 11-12-09 Riverdale, Maryland ment (Donation 5 Other Specify: 9 22. Name and Address of Facility Ronald Taylor II Funeral Home Signat e of Funeral Service Lice ee 108 W. North Avenue, Baltimore, Maryland 21201 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medica Death a. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical XUNPENDED AMENDED physician the burial -23a,27,permE, g897 11/23/09 TT The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Yea 3 Ectopic pregnancy Month Day attending l Fetal death past 12 months Pregnant at time of death Other (Specify) 5 ned by the atte detached for 1 1 Yes 2 No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has performed? 1 🗸 Yes Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No Director: Pending hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) within 24 hours at To the Funeral D determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number November 5, 2009 OCME 30. Name and ddress of rerson who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month State NOV

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 19:40 CHARLES RANDALL GORDON NOV /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FROSTBURG ALLEGANY 10900 WASHINGTON HOLLOW RD 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
U.S.A. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min. FEB 10 1964 214-80-2258 Director Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examina mans to morthled at 1 ☐ Yes 2 No Director FROSTBURG MD ALLEGANY with the 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code 21532 U.S.A. 10900 WASHINGTON HOLLOW RD death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 11. Marital Status Black, White, etc. hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗷 No If Yes, Give Year or Dates Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If Item 27 Is marked oth any liqury or other traumatic event 2008. COLLEEN LANCE GORDON JAMES H. GORDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10900 WASHINGTON HOLLOW RD FROSTBURG, MD 21532 COLLEEN GORDON MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FROSTBURG MEM PARK 11-18-2009 FROSTBURG, MD 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MODES 4 7 60 W. MAIN ST., FROSTBURG, MD 21532 So wers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pertensine Cardiovascular **Physician** years. disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760, Physician/Medical use as 1 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. the 9 ☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Tes 2 No 3 Probably 4 → 4nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 si autopsy certificate I □Yes 2. □ No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral (27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 Natural n 24 hours after death.

In Funeral Director: Aft bletely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D21244 16/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, 4 Broadway, Frostburg MD 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2x

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LUCILLE HICKS Month Medical NOVEMBER 2009 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Days Months Hours Min. Month, Day, Year, JAN 17 1 Director 223-32-1145 VIRGINIA Usual Residence of Decedent and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f show
raumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE'S LANDOVER 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 MOUNTAIN VIEW COURT 20785 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give þ 1 Never Married 2 Married Black, White, etc Baltimore, Maryland 21215-0036 1 Yes 2 XNo BLACK Completed 3

 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10TH DOMESTIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM B. JONES MARY T., GALES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 200 MOUNTAIN VIEW COURT LANDOVER, MARYLAND 20785 JOE C. JONES/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 State 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. FOREST LAWN CEMETERY: 11/8/2009 EMPORIA, VIRGINIA re of Fureral Sarvice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine nding physician and use as the burial-transi RATORY FAILURE Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🔲 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Tyes 2 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Chandy eller MD52855 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

7207B HANOVER PARKWAY GREENBELT, MARYLAND 20770

CHANDRA S. KORAPATI M.D.

31. Date filed (Month, Day, Year)

NOV 0 6 2009

			1 - For State of Maryland / Depart Registrar Certific	tment of Hea			ene _{9. No.} 2009	37156
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MICHAEL SHELDON JACKSON			2. Date of Death Month NOVEMBER		3. Time of Death 2234 M
1	Examin		4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER	b. City, Town, or Lo			4c. County of Deat	h
	Funeral Director		577-88-4790 1 X M 2 □ F 50 Yrs. N		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, AUGUST 19,	9. Birt 1959 WASH	hplace (State or Foreign untry) NGION, D.C.
	the Maryland 28a-f show notified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati MARYLAND CHARLES WALDORF 10e. Street and Number	tion 10f. Zip Code		10	g. Citizen of What Co	10d. Inside City Limits X☐Yes 2☐No
	ath with \$ 23a or nust be r	ral Di	4302 EAGLE TRACE COURT	2060		Ţ	JNITED STA	res
0000	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show marked other than "natural", or items 25a or 28a-f show marked other than "natural".	d by Funeral	3 ☐ Widowed 4 ☐ Divorced		Specify:		14. Race - Ame Black, White Specify: BL	o, etc. ACK
-0171	vithin 72 h ane. Ihan "nati s Medici	Completed	15. Decedent's Education (Specify only highest grade completed) [Specify only highest grade completed] [Siementary/Secondary (0-12) College (1-4or 5+) [Specify only highest grade completed] [Siementary/Secondary (0-12) BUDGET	nt's Usual Occupation of work done durit NOT use retired) TOFFICER	ring most of workin	ng	6b. Kind of Business/	
אוומ ע	be d stal	Be	17. Father's Name (First, Middle, Last)	18	8. Mother's Name	(First, Middle, Ma	aiden Surname)	
Malyi	an as	To	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing A	Address (Street and	nd Number or Rura	I Route Number,	City or Town, State, 2	
alimore,	Pages nent o ant: If		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	on (Name of fory or other place)	D	eate 20	Oc. Location - City or	Town, State
מ	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License THO THO 3439	RNION FUN 9 LIVINGS	NERAL HON STON ROAI	ME, P.A. D, INDIAN	N HEAD, MA	RYLAND 20640
	Physician // / / / / / / / / / / / / / / / / /	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHERO SCLEROTIC CA Due to (or as a consequence of): DIABETES Due to (or as a consequence of): Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				st,	Approximate Interval Between Onset and Death
30x 00/00,	ath certificate be executed ttending physician and or use as the burial-transit	sician/Medical E	d	ctopic pregnancy			23d. Date of de Month	ivery Day Year
5	ires that the death certific signed by the attending is i be detached for use as	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the unde	Other (specify)	in Part I	23e. Did toba	acco use contribute to	
colus,	w requires to been signer should be considered.	ted by	HYPERTENSION					obably 47 Unknown
ם ב	The law rate has be page 2 sh	Completed	- HYPERLIPIDEMIA OBESITY			24a. Was an autopsy perform 1 □ Yes 2	prior to	topsy findings available completion of cause of
<u> </u>	sician: s certific lirector,	Be	25. Was case referred to medical examiner?	Othor	26. Place of Death		nce 6 Other (Spe	a/6.4
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Death 1 Manuer of Death 1 Natural 2 Natural 2 Nacident 3 Suicide 4 Homicide 2 Natural 5 Pending investigation 3 Suicide 4 Homicide 2 Natural 2 Natural 5 Pending investigation 2 Natural 2 Natu	28c. Injury a Work? M 1 □Yes	at 2 es 2 □No	28d. Describe hov		
2	spital or / spours after neral Dire / filled in b			occurred at the time,			iuse(s) and manner a	
	o the Ho rithin 24 I o the Fu ompletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invessand manner stated. 29b. Signature and title of certifier	stigation, in my opin			ete and place, and due	
)	FSFö		aleer the un	D003029	96 MD	NO	OVEMBER 4,	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print DEBORAH THOMPSON, MD 5100 AUTH WAY	SUITLAND	D, MARYLA	AND 2074	46	
	Sta Registr	rar	NOV 0 5 2009 32. Registrar's Signature	Med				
DHI	MH 17 Dov 1/2	001	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar	Cer	rtificate of D	Death		Reg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death Year 6:56 P _M		
	Medic	al	GREGORY JONES				10-30	<u>–2009</u>			
,	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Clintor	Location of Death		4c. County	e George's		
	Francis		Southern Maryland Hospital 5. Social Security Number 6. Sex 17. Age (In yrs. le	st birthdav)	If Under 1 Year		8. Date of Birt		G. Birthplace (State or Foreign		
ı	Funeral Director		579-56-7645 1 № M 2 □ F 62 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.		1947	Country) DC		
	and show	or		y, Town or Lo	cation				10d. Inside City Limits		
	Maryl: 8a-f tifiec	Director	Maryland Prince George's Up	per Ma	arlboro				1X□ Yes 2 □ No		
	a or 2	Ö	10e. Street and Number		10f. Zip Code			10g. Citizen of	Citizen of What Country?		
	is 23.	Funeral	10801 King Edward Drive		20772			USA			
	deatl riter		11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hi If Yes, specify Cuba				ce - American Indian, ck, White, etc.		
36	after al", ol xami	d by	1 Never Married 2 Married 1 Ves 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🏋 No	Specify:		Specify	, Black		
0	hours natura ical E	lete	15. Decedent's Education	16a. Decer	dent's Usual Occupa	ation	- 0	16b. Kind of B	Business Industry		
215	in 72 e. nan "r	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	kind of work done d O NOT use retired)	· ·	ng				
2	ygien ygien her th	a)	1-4	Mas	ster Build				mployed		
and	e filec ntal H ed ot even	To B	17. Father's Name (First, Middle, Last)			18. Mother's Name	, , ,	Maiden Surnam	ne)		
ž	d Mel d Mel mark matic		Clayton Jones 19a. Informant's Name/Relationship (Type, Print)	105 14-99	ng Address (Street a			City of Toyen	State Zin Code)		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Roslyn Foster - Wife	1080	l King Edv	ward Dr.,	Upper	Marlbor	o, MD 20772		
ore	e 1 ar iof H _k if iter				osition (Name of matory or other plac	e)	Date	20c. Location	- City or Town, State		
ţi	t. Pag tment tant: ijury o		4 ☐ Donation 5 ☐ Other (Specify) Ced		11 Cemete		9-2009	Suitla	nd, Maryland		
Bal	Depar Impor any ir		21. Signature of Funeral Service Licensee Mary Hedgman M013	74 Ce	2. Name and Addres edar Hill		PA Ave	e., Suit	land, MD 20746		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line.										
2	Physician/		Immediate Cause (Final disease or condition	d A	8 dominal	aostu	Une	iryou	Onsegand Death		
1	/ Medical Examiner		resulting in death) Due to (or all a consequ	ience of):				O	I de eu a		
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	ence of):					- Jene		
	ted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Ens in	и				years		
	execu an and ial-tra	Ĕ	that initiated events resulting in death) Last C. Due to (s a consequ	ience of):	<u> </u>						
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8760	tifical ing ph	Me	IF FEMALE:								
9 xc	ss that the death cer igned by the attendi be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? in the past 12 months? ↓ □ Feta	aldeath 3	☐ Ectopic pregnand ☐ Other (specify)	:y			ate of delivery onth Day Year		
. Box	the a	iysid	1 Yes 2 No 9 Unknown 9 Unknown	icaii o L		-					
P.O.	that the	by Pi	Part II. Other significant conditions contributing to death but not res	ulting in the ι	underlying cause giv	en in Part I.	23e. Did t	tobacco use con	tribute to the cause of death?		
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ÿör	aw require as been si 2 should	Completed					24a. Was auto		Were autopsy findings available prior to completion of cause of		
Rec	The law ate has page 2 a	Som	W. Dental Control of the Control of					ormed?	death? 1 Yes 2 No		
ta	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?			ace of Death (Chec	k only one)	~			
ξV	Physi this c	일 ::	1 ☐ Yes 2 No 1 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of injury	ER/Outpatie		4 LJ Nursing Ho		dence 6 Oth			
0 0	th. After fune	cate	1 Matural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	work	? Yes 2 □ No	200. Describe	now injury occur	ieu		
Division of Vital Records,	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At ho		reet, factory, office				ber or Rural Route Number,		
Ω̈́	ital or irs afte ral Dir led in		building, etc. (Specify				City or Tou				
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendiction of the funeral director, page 2 should be detached for use to make the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check Check only one) 1 Certifying Physician: To the best of my knowl and the control of the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	n and/or inves	stigation, in my opinio	on, death occurred a	t the time, date	and place, and du	ue to the cause(s) and manner stated.		
	To the within To the comp	2	29b. Signature and title of certifier		29c. License				ed (Month, Day, Year)		
			I amus a year n	N	D-1	42082		Octo	ber 30, 2009		
7	7		30. Name and address of person who completed cause of death (Item 7.50 Suwatts Road Suit	23a) (Type, I	Print)	En M)207	135			
	Sta	te_	31. Date filed (Month, Day Year) \$2. Registrar's Signar	ure	101111	0.01 111	100				
	Registr		NOV 0 6 2009 Senera D. S.	alles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Physician/ Marie I. Johnson October 17:22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Examiner Washington Adventist Hospital Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Days North 80 579-34-6089 Director Carolin Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Washington DC 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20019 4125 Meade Street NE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NOT use retired)

Teacher (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Miller Fred Isler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4125 Meade Street NE Wash, DC 20019 Hattie I. Ford (Daughter) 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cem 11-07-09 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility DC 20011 21. Signatur Funeral Service Censee Tyrone J. Young 719 Kennedy St. NW Wash 23a. Part 1. Enter the disease, or complications the shock, or beart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and sompleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060100 MD 10-29-9 AHMED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 BLVD Sast 20903 University MO

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per phys. G898 1272709 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER ^Di^y. AGNES CLEMENTINE SAVOY LEWIS 2009 13:57 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Hours FEBRUARY 4. 1939 WASHINGTON, D.C. 70 225-84-2652 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MARYLAND **CHARLES** WALDORF 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20602 UNITED STATES 3605 MOSES WAY, APT.#316 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: BLACK If Yes. Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 TH GRADE (0-12) College (1-4 or 5+) HOUSEWIFE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN RICHARD SAVOY AGNES LUCILLE BOWMAN SAVOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVERT P. LEWIS / HUSBAND 3605 MOSES WAY, APT.#316, WALDORF, MARYLAND 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State HERITAGE MEMORIAL CEM NOVEMBER 6,2009 WALDORF, MARYLAND 4 Donation 5 Other (Specify) Structure of Furen LSe Vir License MO0583 22 Name and Address of Facility HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner COLITIS SCHEMIC Sequentially list conditions, Examiner framy leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Jas autopsy perforn 1 ☐ Yes 2 ☐ No 2 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 101. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral L completed filled Medical 29a, Certifier Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121.50 ANNA POLIS RD H205 GLEWN DAVE MO 20169 MOMOH MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NUV 0 5 2009

DHMH 17 Rev 7/2009

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#8 per FH State of Marylan State Registrar AACO HEALTH DEPT. CMH 11/12/09 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 21, 2009 **Physician** Dora R. Marlar 8:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 👿 F Director 579-42-4406 August 31, 2009 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov Director 1 ☐ Yes 2 X No Maryland Montgomery Ashton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17805 Striley Drive 20861 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify. Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Admitting Clerk Montgomery General Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any Injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irwin C. Roudabush Maggie E. Tussing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Lewis-daughter 24010 Bush Hill Road, Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Union Cemetery October 26,2009 Burtonsville, Maryland 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Fleck Funeral Home, INC. MO123 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** +95+9+10 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation thours after death.

uneral Director: Afely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Nothin 24 hours and within 24 hours and To the Funeral Direct Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 136055694 Physicicy 22/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOK MATHUR Olary - Levitoraile MP

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 03

32. Registrar's Signature

09-08528 Troy Moomau

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

roy Moomau		- For State legistrar	Si	tate of Maryla		ertificate of			Menta	al Hy		Reg. No.	20	0	3 3	71	6
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Funeral Director		5. Social Security N		6. Sex		. last birthday)	If Under Months	1 Year Days	If Under: Hours	24Hrs. Min.	8. Date of B	•		Col	intry)		
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Box 6876 : death certificate the attending phy ed for use as the	Physician/w	1 Yes 2 1	No 9 Un	known 9 Unkn	nant at time of one	death 5 Ot	her (Specii	(y)									
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Division of Vital Records, as for Attending Physician: The law requirers after death. al Director: After this certificate has been is after death there is the property of th	Completed										24a. Was		pr		topsy findir ompletion		
tal Rec	5		15.7-156	-35							1 Yes	2 ✓ N		Ye	s 2	No No	
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Ing Phy After th	<u>ا</u>	1 ✓ Yes 27. Manner of Deat	2 No h		e of Injury h, Day,Year)	28b. Time of I			at Work?	<u></u>	28d. Describe	how inju					
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To the Howithin 24 h		(Check only one) 2		miner: On the basis	of examination												
F 3 F 8	ž	29b. Signature and	title of certifi					License					Date signe			ear)	
	L		11/	1 Am				O.C.M	.E.			Nov	ember 6	5, 200	. 		
P OCME		30. Name and addr Mary G. Rip		Deputy Chief			1 Penn S	treet,	Baltimo	re, MI	21201						
Sta	_	31. Date filed (Mon	th, Day, Year)	32. R	egistrar's Signa	ature											_
Registra	21	MOVA	a 2009	7		back											

			For State	State o	of Marylan			lealth and N	/lental Hy	giene		
		_	Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate of E	Jeatn	2. Date of De	Reg. No. 2	009	337, 52
	Physicia Medic		GRACE LOUI		<i>l</i>					2-2009	Year	1:53 P M
	Examin		4a. Facility Name (if not institution,	-	·			Location of Death			nty of Death	
تمميد	Funeral		Washington Adv 5. Social Security Number	S. Sex	7. Age (In yrs. I	ast birthday)	Takoma If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th .	gomery 9. Birthp	lace (State or Foreign
	Director		579-50-0664	1 □ M 2 🏋 F	73	Yrs.	Months Days	Hours Min.	03-06-	1936	Count	
	nd show at	ا اة	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	eation				1	0d. Inside City Limits
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	th the		10e. Street and Number	D 1	-		10f. Zip Code			10g. Citizen o	of What Coun	try?
	ems 2	Funeral	8758 Ritchboro	12. Was Dece	edent Ever in U.S	S. 13. V	20747 Vas Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	USA 14. B	ace - America	an Indian.
7036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	Armed For 1 Yes If Yes, Giv Year or D		- 1	Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)		lack, White, e ify: Blac	
9500-61212	hin 72 hou ne. than "nat u e Medica	ompleted	15. Decedent (Specify only highes Elementary/Seconday (0-12)			(Give I life. Do	O NOT use retired)	ation during most of work			Business Inc	
	ed with Hygien other i	Be C	17. Father's Name (First, Middle, La			Edu	cator	18. Mother's Nam				Col. Gov't
/lan	d be fil Mental arked atic ev	욘	Henry C. William	ns				Betty Wa	rren			
Baltimore, Maryland	d 2 shoul salth and l n 27 is ma er traums		19a. Informant's Name/Relationshi Kim Murphy/Daug					and Number or Run o Rd., Fo				
ore	ge 1 and to the true or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 🗌 Removal from	State o	emetery, cren	sition (Name of natory or other place	:e)	Date		n - City or To	
<u>=</u>	nit. Pagartmer ortant injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service Lie		rın		. Name and Addres	Cem.: 11-1	1-2009	Suitla	and, M	aryland
ñ	permit Depar Impor any in		Mary Hedy	man					PA Ave	., Suit	tland,	MD 20746
	nysician/		23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final	complications that aly one cause on ea	caused the deat	h. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
مرر	Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a cons	,	y .			-		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Jue to	(or as a consequ		rotic	Cardi	ovato	nlay d	Jense	
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_	oe exec ician al	ia E	resulting in death) Last	Due to	(or as a consequ	uence of):						
2/60	certificate be executed inding physician and use as the burial-transi	Medical		d								
Š n	death ne atte ed for	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	nant at time of	al death 3	Ectopic pregnand Other (specify)	су			Date of delive Month	ery Day Year
s, P.O.	The law requires that the ate has been signed by the page 2 should be detach	2	Part II. Other significant condition	ns contributing to o	death but not res	ulting in the u	nderlying cause giv	ven in Part I.				e cause of death?
Division of Vital Records,	e law requ e has beer ge 2 shou	Completed								psy ormed?	prior to cor death?	osy findings available mpletion of cause of
e a	ian: Th rtificate stor, pa	Be Co	25. Was case referred to medical examiner?	1	-/		26. PI	ace of Death (Chec		2 LNO	1 Yes_	2 □ No
<u> </u>	Physic this ce al direc	유	1 Yes 2 No		Inpatient 2	ER/Outpatier		4 L Nursing H				
0	nding I th. : After s funer	cate	1 Natural 5 Pending 2 Accident Investig		of Injury oth, Day, Year)	injury	28c. Injun work M 1 🗆		28d. Describe l	now injury occi	urred	
JINISIO	al or Atter s after des I Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be 28e. Place	e of Injury - At ho ing, etc. (Specif)		eet, factory, office		28f. Location (S City or Tov		nber or Rural	Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seminary.	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examinatio	n and/or invest	igation, in my opinio	date and place, ar on, death occurred a e time, date and place	t the time, date a	and place, and	due to the cau	use(s) and manner stated.
	Vithi Vott		29b. Signature and title of certifier				29c. License	e number		29d. Date sign	ned (Month, L	Day, Year)
			30. Name and address of person w	ho completed as:)	23a) /Time =	hai nath	060100			03-	7
2	. 3		831 Univer	A i	ro Sa	1 L	Silver	HMINA	MA	74 ME	9	
	Sta Registr		31. Date filed (Month, Day, Year) NOV OR 2009	Ceneral 1	Registrar's Signa	ture						

DHMH 17 Rev 7/2009

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State of Mary	yland / Departm	ent of Health an	d Mental Hy	giene 🚄 U U

			For State of Maryland / Department / State Registrar Certificate		u Ment	, ,	g. No.	
			1. Decedent's Name (First, Middle, Last)	· · · · ·		ate of Death	Day Year	3. Time of Death
	Physicia /Medic		Marjorie J. Mitchell			· VC	1, 2009	11:25A M
٠	Examin			wn, or Location of De	eath		4c. County of Deat	h
e de la constante				ver Spri			Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1. Months 5.		lin. (M	ate of Birth fonth, Day,	9. Birt Year) Co	hplace (State or Foreign untry)
	Director		578-68-1831 12 1 2 3 1 1 1 1 1 1 1 2 3 1 1 1 1 1		04	-22-1	944 So.	Carolina
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	f sho	ō	MD PrinceGeorges Laurel					No 1 □ Yes 2 □ No
	the N	Director	10e. Street and Number 10f. Zip Ci	ode		100	g. Citizen of What Co	
	a or	Ö				100	g. Citizeri di winat Co	unitry :
	is 23	era	9695 Murkirk Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	20708	/Specify V	oc or No.	14. Race - Ame	
	iten iten	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1. □ Yes 2 □ No	t of Hispanic Origin? Cuban, Mexican, Pu	erto Rican,	etc.)	Black, White	
215-0036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, it in Modeal Eventher mast be redified at	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☐	No Specify:			Specify:	Black
Ĭ	2 hou	ted	15. Decedent's Education 16a, Decedent's Usual C	Occupation		16	6b. Kind of Business/	Industry
7	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	done during most of v retired)	working			
7	d with giene	E O	12 School B	us Drive	r		Public S	School Sys
פ	e filed v al Hygie other i vent, il	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	Name (First		aiden Surname)	
yland		70 E	Herbert Mitchell	Carr	ie Ta	aylor		
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	Ē.,	19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (S	treet and Number or	Rural Rout	te Number, (City or Town, State, 2	Zip Code)
Ma	1 and 2 Health a em 27 to		Dianna Woods (Daughter) Odenton,	gadier B. Marvlan	g Tva•	21113		
ē.	is 1 ar		20a. Method of Disposition 20b. Place of Disposition (Name	of	Date		Oc. Location - City or	Town, State
Ĕ	Pages nent of ant: If its ary or o		1月 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Nat. Mem.]		-07-2	2009	Laure1	, MD
saitimore	permit. Pages Department of Important: If is any Injury or once.						al Servi	
ñ	De la la la la la la la la la la la la la	: 8					r.Bowie,	
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of					Approximate
	Physician	8 4	shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Interval Between Onset and Death
	/Medical	Ш	disease or condition resulting in death) a Respiratory Failure Due to (or as a consequence of):	3				
	Examiner		Pulmonary Embolism					
	-	ē	Sequentially list conditions, if any, leading to him ordinate cause. Enter Underlying Cause (Disease or Injury that initiated events c. Venous Thrombosis					
	uted d ansit	Ē	cause Disease or injury Venous Thrombosis					
,	exec in an ial-tr	Examiner	resulting in death) Last Due to (or as a consequence of):					
00/00	rificate be executed g physician and as the burial-transit	cal	Recurrent Carcinoma	a				
00	g phy as th	edical						
Š	n cer	₹	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of del	ivery
0	death d for	sician/	in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic preg 1 □ Ves 2 🕅 No. 4 □ Pregnant at time of death 5 □ Other (spec				Month	Day Year
5	t the by th ache	Phys	9 Unknown					
,	e law requires that the death cer has been signed by the attendir e 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	2:	3e. Did toba	acco use contribute to	the cause of death?
cords,	quire				_ 1	1 ☐ Yes	2 ⊈ No 3 □ Pr	obably 4 🗌 Unknown
ວ	s bee	et			24	4a. Was an	24b. Were au	topsy findings available
č	The la	Completed			_	autopsy performe	ed? death?	completion of cause of
N I G	siclan: The certificate rector, pag	a	25. Was case referred to medical	26. Place of D		_		2 13No
>	Attending Physician: The law requires that the death cer rideath. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	70 B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other:			ce 6 ☐Other (Spe	cifu)
5	g Ph er th eral	ᇤ	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.	Injury at			injury occurred	ony)
VISION	th.	엹	11█ Natural 5 ☐ Pending (Month, Ďay, Year) Injury 2 ☐ Accident investigation M	Work? 1 □ Yes 2 □ No				
2	Atte ecto by th	<u>i</u>	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined building, etc. (Specify)	fice	28f. Lo	cation (Stre	et and Number or Ru	ıral Route Number,
5	al or	Certification:	4 Homicide building, etc. (Specify)		C	ty or Town,	State)	
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at	the time, date and pla	ace, and du	ue to the cau	use(s) and manner as	s stated.
	n 24 n 24 ne Fu	Medical	(Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death or	ccurred at t	he time, dat	e and place, and due	to the cause(s)
	Vithi Vithi Comp	ž	29b. Signature and title of certifier 29c. L	iceps number	7	290	d. Date signed (Mont	
	al.		Puint xy/	50010			11-05-20	009
ÍΛ	6	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0				
L			Albert J. Steren, MD 6301 Executive	Bld. Roo	ckvi]	lle,	MD 2085	2
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Structure	-				
	Registra	77.0	BILLY II E /ITIS / Parada A C/. APPROVE					

DHMH 17 Rev 1/2001

Physician /Medical Examiner Physician/Medical Examiner

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar

this certificate

þ

Be Completed

Certification: To

Medical

Physician

Examiner

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Exercised at the notified at

other traumatic event, the Mudical

h and Mental P

f Health

permit. Pages Department of Important: If It any Injury or o

Director

Funeral

Be Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

5 Other (specify)

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco us	se con	indule to t	ne cau	ise of death?
1 □ Yes 2 □] No	3□ Pro	bably	4 Unknow
24a. Was en autopsy performed? 1 □Yes 2 ☒No		Were euto prior to co death? 1 □Yes		ndings available on of cause of

25. Was case referred to medical

performed: 1 ☐Yes 26. Place of Death (Check only one)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending

Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Yes 2 No

27. Manner of Death

2 Accident 3 Suicide

4 Homicide

1 XXNatural

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

investigation

6 Could not be determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tammie Kerns MD 6825 16th Street N.W. Washington, D.C. 20307

Registrar

To the Hospital or Automorphin 24 hours after death.

To the Funeral Director: Aft

31. Date filed (Month, Day Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 0 31, 2009 10:05 A^M Evelyn Massengill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** National Lutheran Home Rockville Montgomery 8. Date of Birth Month, Day, You MAR • 21 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. , Year 915 Months Days Hours MINNESOTA 1 □ M 2**X** F 94 Yrs. 318-32-0091 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD. MONTGOMERY ROCKVILLE 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 VEIRS DRIVE 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WHITE 1 □Yes 2X No Specify Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL TECHNOLOGIST HEALTH 5+ nd Mental Hygie marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT LAURENCE FRANCES SWANSON traumatic ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (n) 3131 CASTLELEIGH RD., SILVER SPRING, MD. 2090 MRS.KAREN MILLS-DAUGHTER 27 permit. Pages 1 and:
Department of Heath
Important: If Item 27
any injury or other tro
once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/2/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility
YSONG CO. 2222-WISCONSIN AVE., NW 21. Signature of Funeral Servi W. hr HYSONG CO. om licatio is to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and an each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final metastatic **Physician** brain disease or condition resulting in death) elus (/Medical Due to (or as a consequence of): Examiner 4eur 2V19 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. signed by the a 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Nknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division 5 ☐ Pending investigation 1 Natural
2 Accident To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

CR

State Registrar SAMEL G. MAILER MD

II. Date filed (Month, Day, Year)

NOV 0 4 2009 Server S. J.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TEND 97:0/ Veirs Drive Lockville Maryland 2085 0

32-Registrar's Signature

maller M. D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Dorothy P. Marinari 30, 2009 6:45P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 27, 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 1 □ M 2 🗓 F Days Hours 579-30-6414 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George Ft. Washington 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4603 Ballad Drive 20744 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🗓 No White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Ceramic's Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Patton Minnie Brown _____ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4603 Ballad Drive Fort Washington, MD. 20744 Mario R. Marinari/Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Kalas Crematory or other 1 Burial 2 💹 Cremation 3 🗆 Removal from State 11/1/2009 Edgewater, MD. 5 Other (Specify) 4 Donatio 22. Name and Address of Facility George P. Kalas Funeral Home Signature 6160 Oxon Hill Rd. Oxon Hill, MD. 20745

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

23a, Fa.7. Enter the disease or co sh. k, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplication with a caused the dear one cause on each line. Due to (or as a consec	SCLEADI		1	WAR	Approximate Interval Between Orset and Beath
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consector) C. Due to (or as a consector) d	,				YEAVS
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🔲 Ectopic pr		· · ·	23d. Date of de Month	blivery Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying ca	use given in Part I.	1 X Yes	2 □ No 3 □ F	o the cause of death? Probably 4 Unknown
				24a. Was an autopsy performed? 1 \(\sum \) Yes 2	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
1 ☐ Yes 2 ☒ No	Hospital:	BR/Outpatient 3 DO/	Other:	lome 5 🗆 Residence	6 Other (Spec	cifv)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury M	c. Injury at work? 1 🗌 Yes 2 🗌 No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ome, farm, street, factory,	office	28f. Location (Street a City or Town, Sta		ıral Route Number,
	nysician: To the best of my know miner: On the basis of examination					

🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

OLD LINE CO

State Registrar completed cause of death (Item 23a) (Type, Print)

			State of Maryland	•	rtment of H tificate of I				0 07167
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of t	Jean	2. Date of Dea	Reg. No. 200	3. Time of Death
	Physicia /Medic		JOHNNIE MAE MORGAN				Oct.	31 2009	
	Examin	er	4a. Facility Name (If not institution, give street and number)		**	Location of Death		4c. County of De	
	Funeral	-	6317 Danner Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthdav)	Clinto	II If Under 24 Hrs.	8. Date of Birtl	Prince (irthplace (State or Foreign
	Funeral Director		463-30-1546 1□M 2□XF 84	Yrs.	Months Days	Hours Min.	(Month, Da) Sep 1	(, Year)	Country) TX
	pu ,		Usual Residence of Decedent						Table to the On the N
	arylar shov	'n	, , , , , , , , , , , , , , , , , , , ,	Town or Loc	eation				10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	MD Prince Georges Cli	inton	10f, Zip Code			10g. Citizen of What 0	
	3a or		6317 Danner Dr.		207	35		USA	,,,,,,,
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-	14. Race - An	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it is it is a mind be reallfished.	y Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		Yes 2 XNo	in, Mexican, Puerto Specify:	nican, etc.)	Black, Wh	ite, etc.
21215-0036	hours tural"	ed by	3 LAWidowed 4 LI Divorced Year or Dates:	16a Dagad	ent's Usual Occupa	ation			Black
15	in 72 n "na"	Completed	(Specify only highest grade completed)	(Give I life. D	kind of work done of NOT use retired	during most of work f)	ing	16b. Killa of Busilles	s/industry
212	d with giene er tha	No.	Elementary/Secondary (0-12) College (1-4or 5+) 12th	Perso	nnel Cle	rk		Bureau	of Census
Maryland	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
yla	d Men narke	၀	Johnny L. Clark			Hester 1			
Ma	d 2 sh th and ?7 is n traun	9 8						r, City or Town, State	, Zip Code)
ē,	f Heal	1	Kevin L. MOrgan - Son 20a. Method of Disposition 20b. Plac		Danner D sition (Name of leatory or other place		on, Md.	20c. Location - City of	or Town, State
E E	Page: Tent o nt; If ry or		La Buriai 2 Li Cremation 3 Li Removal from State		n Nation	. i	-2009	Suitland,	1d .
Baltimore,	rmit. spartn porta y inju		21. Signature of Funeral Service Licensee	-				f Maryland	
<u> </u>	9 2 E E 6		Victoriae & ababs)		308 Suit			nd, Md. 20	
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death) a. End Stage Chyresulting in death)		Pulmonar	y Disease	e		yrs
	/Medical Examiner		Due to (or as a consequer	nce of):					W.C.
		er	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause, Olsease or injury Hypoal huminer	nea of):					yrs
	cuted nd ransit	Examiner	that initiated events c c.						
ó,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last Due to (or as a consequer	,					
68760,	cate b	edical	d. Hypercholeste	erolen	nia				
9	leath certifi attending for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	ev.				23d. Date of c	lolivery
Box	death e atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 4 ☐ Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)	У		Month	Day Year
P. O.	at the de by the tached	hysi	9 ☐ Unknown						
	es the	by F	Part II. Other significant conditions contributing to death but not resulting		, 0	en in Part I.			to the cause of death?
ord	w requires been si should b	ted	Myocardial Ischemia, Immunibilit	ty Syr	ndrome		1 🗆 Y	es 2□No 3□	Probably 4 X Unknown
Records,	a = a	Completed	Hypocalemia, Aneroxia				24a. Was a autop	sy prior t	autopsy findings available occupietion of cause of
	sician: The certificate hi rector, page						perfor 1 □ Yes	2 🛣 No 1 □ Ye	es 2 🖾 No
₹	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	R/Outnation	Othe	26. Place of Deat		<i>ne)</i> lence 6 □Other <i>(S)</i>	agaiful
٥	5 9 9 9	\vdash	27. Manner of Death 28a. Date of Injury 20	8b. Time of Injury	28c. Injury Work			ow injury occurred	Эвспу)
Sior	Attending ir death. ector: After by the fune	atio	2 Accident investigation	myary		Yes 2□No			
Division of Vital	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
	pital ours a eral D filled i		29a. Certifier 1 ★ Certifying Physician: To the best of my knowle	edge death	occurred at the tir	me date and place	and due to the	cause(s) and manner	as stated
	ie Hos 1 24 hr ie Fun detely	Medical	(Check only 2 Medical Examiner: On the basis of examinatio one)						
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft Completely filled in by the fun	Me	29b. Signature and title of bertifier	ml	29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
	a		· Weller Kelley	M	D547	49		Nov. 3,	2009
	20		30. Name and address of person who completed cause of dath (Item 2 Allen Reilly, M.D. 801 Tollhous			D1 Fre	derick.	MD. 21701	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	·e					
	Registra		NOV 0 5 2009 Proceed A.	arken	7				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year O'Connor Keith 10:05 A M 009 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours XX M 2 D F 52 June 6, Year 957 Washington DC Director 72 3445 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 XXVo Marvland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20745 United States 6541 Bock Terrace 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Yes 2 XXVo If Yes, Give Year or Dates. "natural", or XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 TNO Specify: Specify: White Completed 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mobile Sales Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever and Mental I ပ Ellen May Shaw O'Connor Aloysius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen O'Connor (Mother) 6541 Bock Terrace, Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory Nov 5, 2009 Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Clinton, MD Alexandria Ferry Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) no Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a co and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 🗌 No 3 Probably 4 Dinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 40 ည 1 phpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of Certificate; 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No 1 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check furse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar

State Registrar

DHMH 17 Rev 7/2009

235

on who completed cause of death (Item 23a) (Type, Print)

5 2009

Registrar's Signature

09-08435 Jabari Outtz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oaban Ootiz		1- For State Certificate of Death	vicitai riygi	Reg. N	200	19 3716
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)	_ N	Date of Death	y Year	3. Time of Death
Medical Examin		JABARI OUTTZ	0	ctober 31, 2	2009	0348 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca S/B Baltimore Washington Parkway Rt. 50 Cheverly, MD	ation of Death		4c. County of Death Prince George	
	4	, , , , , , , , , , , , , , , , , , ,	f Under 24Hrs. 8.	Date of Birth(N	_	
Funeral Director		218-11-8647		5/1/197		thplace (State or InWashington ^{untry)} DC
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* 1		Maryland Prince George's Greenbelt				1 X Yes 2 No
Maryland 28a-f show datonce.	Director	106. Street and Number 10f. Zip Code		10g.	Citizen of What Coul	ntry?
the M a or 2		6227 Springhill Court # 103 20770		Un	ited Stat	es
n with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani		y Yes or No-	14. Race - Amer White, etc.	ican Indian, Black,
r deatl	띪	1 Yes 2 X No		, ,	Specific — a	_
s afte rral",	ক্র	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No sp. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (done 116	Specify: Bla	ck Industry
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retired)			
036 thin 7 ne.	du	12 10 Research Analysi	t	o	utta & As	sociates
5-0(led wi Hygien other		17. Father's Name (First, Middle, Last) 18.N	Mother's Name (Fir	st, Middle, Maid	den Sumame)	= 00=222=111.50=2
21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica			Janice Ha	amilton	r City or Town State	Zin Code)
MD 2 td 2 shoul lift and M m 27 is m aumatic	-					
and 2 lealth tem 2 traun	ł	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter		ate 2	Oc. Location - City or	Town, State
DOFE ages I at of F other	ı	1 X Burial 2 Cremation 3 Removal from State crematory or other place)	11/7/	2000	Danii 1 - am	#11 a MD
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: Lakemont Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of	FacilityPone	<u> 2009 </u> Funeral	Davidsonv Homes, P	A.
ii ii Dep		(Xanada (timmora) 5538 Marlboro	o Pike Fo	orestvi	lle, Mary	land 20747
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	ch as cardiac or re	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical raminer		Immediate Cause (Final disease a Head and Neck Injuries				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death 1 ast Due to (or as a consequence of):				
uted Id ansit		events resulting in death) Last Due to (or as a consequence or): d.				
c.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	Medical	UNPENDED AMENDED				
760, icate b		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the]		23d. Date of deliver	·
Box 687 e death certific the attending ped for use as the	Physician/	past 12 months? 1 Live birth 2 Fetal death 3 1 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	<i>'</i>	Month	Day Year
Box death he atte	ysi	1 Yes 2 No 9 Unknown g Unknown				
P.O. es that the igned by t	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.			o the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach				24a. Was an		utopsy findings available
ord w req as bee	Completed			autopsy performe	prior to	completion of cause of
Rec The la	팃			1 ✓ Yes 2		
Vital Rec ysician: The l his certificate l	Be	evaminer?	f Death (Check only ther Nursing F		esidence 6 🗸 Oth	ori Canno
f Vid	٩	1 ✓ Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury a			w injury occurred	er: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after cleath. "I Director: After this certificate has been siled in by the funeral director, page 2 should be	ion:	(Month Day Year)			auto accident	
ivisior or Attendather death Director:	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office build	Iding, etc. 28			Rural Route Number, City
Divis pital or At ours after d feral Direct	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	S/I	or Town, Stat B Baltimore V	te) Vashington Parkw	ay Rt. 50, Cheverly, M
Hos Fun Fun	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and du leath occurred at th	e to the cause(ne time, date an	s) and manner as stand place, and due to t	ated. the cause(s)
To the within To the comple	Med	29b. Sonature and title of certifier 29c. License n			29d. Date signed (M	
5		O.C.M.	.E.		October 31, 200	09
		30. Name and address of person who completed cause of death (Item 23a)				
6		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201			
St Regist	ate					
	121	THE THE RESIDENCE OF THE PROPERTY OF THE PROPE				

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month David S. Proctor 2009 November 3:35 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 25, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Hours 215-48-3908 63 **Director** 1946 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file 23s or 28a-f sho sant: If item 27 is marked other than "natural", or items 23s or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21 Silverwood Circle, Unit 5 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 XXVIII Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Collections State of Maryland 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Proctor Sarah Stryker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 Sharon E. Proctor/wife 21 Silverwood Circle, Unit 5 Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Baltimore Crematory: 11/5/2009 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1 shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death gastro intestrul Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be signed by the attending pd be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail 30.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 1 Yes 2 No I or Attending Physician; after death. within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မှ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 28686 09 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

1005 31. Date filed (Month

Box 68760

P.O.

Records,

of Vital

Division

21015

15 Q

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2009

			State Registrar		Ce	rtificate of I	Death		R	eg. No.		
	Division		1. Decedent's Name (First, Middle	e, Last)					. Date of Deat		V	3. Time of Death
	Physici /Medio		Beverly L.	Poole				C	october)	27, 2	.00°9°	10:54 P ^M
and.	Examir		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or	r Location of	of Death		4c. Count	y of Death	10.74 [
			Sinai Hospit	al of Baltimo	ore]	Baltin	nore				
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8.	. Date of Birth	16	9. Birthp	place (State or Foreign
	Director		214-52-7240	1□ M 2 X F	50 Yrs.	Months Days	Hours	Min. Au	(Month Day,	1959	Mary	land
			Usual Residence of Decedent									
	ylan how	١.	10a. State 10b. County		10c. City, Town or Lo	ocation					1	0d. Inside City Limits
	a-fs	흕	Maryland Mon	tgomery		Dickerso	n					1 □Yes 2 No
	r 28	Directo	10e. Street and Number			10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	3a o		221EE Dialeaman	- Cabaal Daal		2004				TT	1 0-	
	ms 2	Funeral	22155 Dickerso	12. Was Decedent Ev	er in U.S. 13.	2084 Was Decedent of H If Yes, specify Cuba		gin? (Specif	fy Yes or No-	United 14. Ra	ce - Americ	
ယ	or ite		1 X Never Married 2 ☐ Marr	Armed Forces? ried 1 ☐ Yes 2 🛣 No)			i, Puerto Ric	can, etc.)	Bla	ack, White,	etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, Its Medical Exx ainst must be notified at	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:			Speci	fy: W	hite
9	2 ho	Completed	15. Deceden	t's Education	16a. Dece	dent's Usual Occup	ation			16b. Kind of E	Business/Ind	dustry
21,5	in 7	ble	(Specify only highest Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life	kind of work done of DO NOT use retired	during most d)	of working	"			
7	d with	E O	Elomomary/occordary (0-12)	+2		memaker				0	wn Ho	me
	e filed Il Hygi other ent, I	Be C	17. Father's Name (First, Middle,	Last)	<u></u>		18. Mother	r's Name <i>(F</i>	irst, Middle, N	Aaiden Surnai	me)	
ä	lid be lental rked c	To B	Charles Poole					Ch.	irley	Jhito		
Maryland	ges 1 and 2 should be filed within t of Heath and Mental Hygiene. If iten 27 is marked other than or other traumatic event, the Me		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailir	ng Address (Street	and Number				n. State. Zio	Cade)
ž	and 2 ealth a n 27 Is ter trai		Charles Poole	/ Father		55 Dicker				•		,
ē,	tem tem tem		20a. Method of Disposition	/ Idenei	20b. Place of Dispo	sition (Name of		Date		20c. Location		
2	Pages nent of int: If its iry or o		1 Burial 2 Cremation		cemetery, crer	matory`or other plac	· ;	_			•	·
Baltimore,	artme		4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service			Cemetery 2. Name and Addres					The second second	, Maryland
Ba	permit. Page Department Important: If any injury o	5 6	21. Orginator of Fulleral Service	Lice Land	-			3	tauffe			
	6		220 Part 1 Enter the distance of	- Jange	Z						rick,	MD 21702
			23a Part 1. Enter the disease, or shock, or hear failure. List	only one cause on each line	ne death. Do not ent	er the mode of dyin	ng, such as d	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
- w.	Physician		Immediate Cause (Final disease or condition	_a. Pulmou	1 acu Ef	FUSIONS						luitk
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							2
П			Sequentially list conditions	b. UVOR	idN Cd	NCER						dyERRS
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							J
	acute ind trans	am	Cause (Disease or injury that initiated events	c								
Ö,	e exi	ω	resulting in death) Last	Due to (or as a	consequence of):							
68760,	certificate be executed ding physician and se as the burial-transit	edical		d								
3	ng pl	/Med	IF FEMALE:									-
			23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		☐ Ectopic pregnancy	,			23d. Da	ate of delive	ery
	dea he at	ici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at ti		Other (specify)	y 			M	onth	Day Year
P. 0.	tt the	Physicia	9 Unknown	9 🗆 ONKNOWN								
o, I	law requires that the death as been signed by the atter 2 should be detached for u	by P	Part II. Other significant condition	ons contributing to death but	not resulting in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use con	tribute to th	e cause of death?
Vital Records,	quire an siç uld b	be	Hypothyloid						1 □ Ye	s 2 146	3 ☐ Prob	ably 4 🗌 Unknown
္ဌ	w re	Completed	Diagiani C	DINCER				1	24a. Was ar	24b.	Were autor	psy findings available
æ	he law e has age 2 a	Ĕ	Ol- To V						autops	v L	prior to cor death?	npletion of cause of
ह	n: T ificat or, p&		25. Was case referred to nedical						1 ☐ Yes 2		1 ☐ Yes	2 🗆 No
5	sicia cert rect	Be	examiner?	Hospital:		Othe	ar.		Check only one	,		
0	Phy rthis rald	Certification: To	27. Manner of Death	I Sampatient		I 3 L DOA	4 🗀 Nur		5 Reside			y)
ב	ding J. Afte fune	<u>[</u>	1 Natural 5 ☐ Pending		Year) Injury	Work	yan (? Yes 2 □ N		i. Describe no	w irijury occur	reu	
2	deatl deatl tor: / the	ica	3 ☐ Suicide 6 ☐ Could n	ot be	/ - At home, farm, stre		res Z LIN		Logotian (C4)			10-1-N-1
Division of	or A after Direct in by	팊	4 ☐ Homicide determi	building, etc.	(Specify)	eet, lactory, office		201.	City or Town	eet and Numi , State)	per or Hura	l Route Number,
1	purs ours eral filled		29a, Certifier 1 Certifyin	g Physician: To the best of	my knowledge de-t	a consurred at the *!-	no doto o	d =laa= = =	d alua de Al-			tota d
	to the flospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	Examiner : On the basis of e	xamination and/or in	vestigation, in my o	ne, uate and pinion, deatl	d place, and th occurred	at the time, da	ause(s) and mate and place,	and due to	the cause(s)
	thin the sumple	Mec	29b. Signature and title of certifier	and manner state	ru.	29c. License	number		20	d. Date signe	d (Month	Day Veer
	2 2 2 2	_	N A R					201	- 1			
		-	111			K.	[J - C		0	CODE	12 50	, 2009
Ĭ			30. Name and address of person	who completed cause of dea	th (Item 23a) (Type,	Print)	4	11	tha 1	0 1	11-	, 2009 10e E
Ì			nndana	N. Pla	C/M 140	DIN	101	1+05P	1621	OF 12	OLLIM	DRE
	Stat		31. Date filed (Month, Day, Year)	32. Regiştra	s Signature			T F				

Registrar

09-08449 Emanuel Palmer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 37172

	1. R	For State egistrarATE10#19a.Per	FHPGC11-6-	09ar (Certificat	te of	Death			1.0		Reg. No.		13	Time of Death
Physicia edical Examir	in/ ner	Decedent's Name (First, Middle, Last) Emanuel Palmer							2. Date of De Month October	31, 20	Year 09	İ	1638 hrs		
		4a. Facility Name (in that institution, give subset and					b. City, Tov Laurel	y, Town, or Location of Death urel			F	4c. County of Death Prince George's			
Funeral Director	1	5. Social Security Number	6. Sex			If Under Months			8. Date of Birth(MM/DD/YYY) 03/25/81		l-	YY) 9. Birthplace (State or Foreign Country) DC			
		577-08-4708 Usual Residence of Decedent	1 X M 2	F	28	Yrs.	1			<u> </u>	037	2370	4		
any		10a. State 10b. County 10c. City, Town or Location								1	X Yes 2 No				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marked of the manual Hygiene. Important: I filem 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be neitfied at mar.	5	OC			W	ash	ingto			_		10a Ci	tizen of What		
	Director	10e. Street and Number					10f. Zip C								
		2300 Good Ho	pe Rd. S	E # 7		13 Wa	s Decedent	2002	anic Origi	n? (Spe	ecify Yes or I		Inited 14. Race -	Sta America	tes n Indian, Black,
ath wir	Funeral	11. Marital Status 1 X Never Married 2	Married Arme	d Forces?		If Y	es, specify	Cuban,	Mexican,	Puerto F	Rican, etc.)		White,	etc.	
ter des	교	3 Widowed 4 D	vorced If Yes, Give					Yes 2 X No specify: s Usual Occupation (Give kind of work done					Specify: T		
ours af atural camin	d by	15. Decedent's Education (Sp	ecify only highest		ed) 16a. D	eceder luring m	nt's Usual O nost of work	ccupati ing life.	on (Give ki	ind of w use retir	ork done ed)	16b	. Kind of Busi	ness/Ind	lustry
6 an "n cal Ex	Completed	Elementary/Secondary (0-12) Collec	ge (1-4 or 5+)	l l	_	ager (Priv	ate	
5-0036 led within 7 Hygiene. I other than the Medica	팅	17. Father's Name (First, Middl	e Last)	2		Mana	ager c) <u>1 </u>	8.Mother's	s Name	(First, Middle	e, Maide	n Surname)		
215- be filed ntal Hyg rked otl	Be	Bradshaw Wi		1mer					Re	osal	ind A	. Yo	ung		
212 Auld be Ments mark mark	To B	19a. Informant's Name/Relation	nship (Type, Print)									City or Town		
MD of 2 sho lith and m 27 is aumati		Rosalind Your	Mothe	r	20b. Place o	300	Good	Hop	e Rd	. SE	# 72	1 W	c. Location -	DC City or T	20020 own, State
re, land I Heal		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Remov	val from State	cremato	ory or o	ther place)	e or cer	netery,						
Pages nent of ant: I		4 Donation 5 Other	Specify:	0	Ft.	Lin	coln_		- (Facility		107/09		Brentv eral T		
Baltimore, permit. Pages 1 an Department of Hea Important: If ites injury or other tr		.Sign ture of Funeral	Lice see	The state of	. 111	22.	Name and	Address Lann	ino R	≀ St Rd.	ewart NE Wa	ishi:	ngton,	DC	20019
		4001 Benning Rd. NE Washington, DC 20019 4001 Benning Rd. NE Washington, DC Approximate Interpretation of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset are													
Physician /Medical		fure. List only one cau	se on each line.	Gunshot \											Death
`xaminer		Immediate Cause (Final disea or condition resulting in death		as a consequ											
		Sequentially list conditions,	b			_		_			_	_			
	Examiner	if any, leading to immediate cause. Enter Underlying Cau	se c	r as a consequ	ence or).										
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vecuted n and - transit	1 =	- INDENDED	d	DED.											
760, icate be exe physician at the burial -	/Medical	UNPENDED IF FEMALE:		yes, outcome	of pregnancy								23d. Date of	delivery	1
68760, certificate be nding physicise as the buri	J.	23b. Was decedent pregnant i past 12 months?	n the 1	Live birth		2 🔲 F	Fetal death	3	Ectopi	c pregn	ancy		Month	D	ay Year
Box 68 as death certiff the attending ed for use as t	sician		Laboration	Pregnant at tim Unknown	ne of death	5 (Other (Spe	cify)				-			
D. Be to the de by the ached f	'ع ا	Part II. Other significant cor	- 1		ut not resultir	ng in the	e underlying	cause	given in P	art I.	4				the cause of death
, P.O. ires that th signed by be detach	2										1	Yes			ably 4 Unkno
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e law	Ē		· · ·									erforme res 2		death? ✓ Ye	es 2 N
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and commissive filled in the fineral director, nace 2 should be detached for use as the burial - transit	၂ ပိ	25. Was case referred to med	fical					26.Plac		n (Checl	k only one)				
	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient	2 ER/0	Outpatie	ent 3 1	OOA	Other ₄		ing Home		sidence 6		r: Scene
	L L	27 Manner of Death	28a	. Date of Injury (Month, Day,Yea UND:	28b.	. Time o	of Injury		ury at Wor Yes 2 ♥		Subject		v injury occur	reu	
	ati	1 Natural 5 F	renaing Or	t 31 2009	162	27 hrs	les et de stor				28f Local	tion (Stre	eet and Numb	oer or Ri	ral Route Number,
IVIS or At after of Direc	Certification:	3 Suicide 6	ould not be	e. Place of Inju		farm, si	treet, ractor	y, onice	Dulluling, (etc.	28f. Location (Street and Number or Rural Route Number, or Town, State) 13000 Larchdale Road, Laurel, MD				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	<u>S</u>			he best of my	1 1	eath oc	curred at th	e time,	date and p	olace, ar	nd due to the	cause(s) and manne	er as stat	ed.
the H thin 24 the F	Medical	(Check only one) 2 Medical	Examiner:On the	basis of exami	nation and/or	rinvesti	igation, in m	y opinio	on, death o	occurred	d at the time,	uate an	piace, and		
To To	S S	and manner stated. 29b signature and title of certifier					29	29c. License number			- 1	29d. Date signed (Month, Day, Year) November 1, 2009			
		30. Name and address of person who completed cause of death (Item 23a)													
25		30. Name and address of pe Laron Locke MD.	rson who complete Assistant M	ed cause of de edical Exar	atn (Item 23a miner 1) 11 Pe	nn Stree	t, Bal	timore, l	MD 21	1201				
	Stat	31. Date filed (Month, Day, Y		32. Registrar	s Signature	11 1	,								
January Company	istra		J Ckned	de B.	far	FIION									
Limbon Li Rev	UZUU					orusus)	THE REAL PROPERTY.								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 10/28/09 4:20 Jerome Alvin Perkins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Magnolia Center Lanham Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) 01/18/28 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) Days Months 577-34-6254 1 ☑ M 2 □ F DC 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the "Modical Examinar must be notified at 10a State 1 ☑ Yes 2 ☐ No Funeral Director Prince George Upper Marlboro Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 13110 Eddington Dr. 20774 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TayYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Maryland 21215-0036 1 □Yes 2 No Specify Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Government s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th other traumatic event, Ins 12th Publications Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Brothers Leroy Perkins ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Upper Marlboro, MD 20774 70 Joyceton Way permit. Pages 1 and Department of Health Important; if item 27 any Injury or other tr once. Ann S. Hinnant/ Daughter altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/05/09 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) Harmony 21. Si kature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Vascular Accident /Medical Due to (or as a consequence of) Examiner Insulin Dependant Sequentially list conditions, ner Dust to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Exami Hypertension and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical Renal Insufficiency the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural ie Hospius. in 24 hours after death. the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0021925 11/05/09 MUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9560 Pennsylvania Ave. Ste. 202 Upper Marlboro, Md. 20772

Registrar

State

Delbert L. Perkins

NOV 0 6 2009

31. Date filed (Month, Day, Year,

			For State	State of M	aryland	•		lealth and f	Mental Hy	giene	0000	07171
			Registrar			Cer	tificate of	Death ———		Reg. No.	2009	3/1/4
	Physici /Medic		1. Decedent's Name (First, Mi Elaine	E.		Perry			2. Date of De Month Oct 31	Day	9 Year	3. Time of Death 6:41p
	Examir		4a. Facility Name (If not institu	tion, give street and number)			4b. City, Town, or	Location of Death	1	4c. (County of Death	1
			Prince George				Chever15		T (D)		ince Geo	
	Funeral Director		5. Social Security Number 578-44-1315	6. Sex 7. Ag	9e (In yrs. Ia	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 1	th ly, Year) 8 193		nplace (State or Foreign untry) nington DC
	and w		Usual Residence of Decedent 10a. State 10b. Coul	ntv	10c. City	. Town or Loc	ation					10d. Inside City Limits
	Maryla f sho	ļō		ce George's		lensbu:						1ÆYes 2 □ No
	r 28a	Director	10e. Street and Number	se dedige 3	Diac	iensbu.	10f. Zip Code			10g. Citiz	zen of What Cou	untry?
	h with		4277 58th Ave	nue #4			20	710		U.S	.A.	
	ems deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities are considered at once.	þ	1 ☐ Never Married 2 ☐ M 3 🌁 Widowed 4 ☐ Divord	If Voc Givo	No		☐Yes 2MNo	Specify:	Triodii, cici,			lack
2-0	72 ho 'natur	Completed	15. Deced (Specify only hig	dent's Education thest grade completed)		16a. Deced	ent's Usual Occup	ation during most of work	king	16b. Kin	nd of Business/II	ndustry
121	within iene. than '	dmo	Elementary/Secondary (0-12	College (1-4or 5	5+)		<i>no not us</i> e retired mer Serv		_	Gove	ernment	
d 2	Hygi other ent, I	Be C	17. Father's Name (First, Midd			04000		18. Mother's Nam	ne (First, Middle,			
lan	Aenta Aenta rked tic ev	To B	Albert Lee Pi	nkney				Grace Ra	ndolph			
lar,	shou and h is ma auma		19a. Informant's Name/Relation			I	- '	and Number or Ru				
≥ .	and the sealth m 27 her tr		Tia L. Cunning	gham/granddau	ghter	6719	Eldridge	Street,				
Ore	ges 1 If itel or ot		20a. Method of Disposition † ☐ Burial 2 ☐ Crematic	n 3 Removal from State	20b. Pl	ace of Dispos metery, crem	ition (Name of atory or other plac	e)	Date	20c. Loc	cation - City or T	Town, State
Ħ	it. Pa irtmer irtant: njury		4 Donation 5 Dother 21. Signature of uneral Sarvi		Harr		emetery	Nov	7 2009	Lando	over, M	D
Ba	permi Depa Impo any Ir		21. Signature of uneral sarvi)				ss of Facility J. ver Road,				
			23a. Part 1. Enter the disease shock, or heart failure. L	or complications that caused ist only one cause on each li	d the death. ne.	. Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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		-er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to or as	a conseque	ence of);	10000					
	cuted nd ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	1. Ro	nat farliere							
oʻ	e exe ian aı urial-t		resulting in death) Last	Due to (or as	a conseque	ence of			///			
68760,	ificate be executed g physician and as the burial-transit	edical		d	20	tro	myo	pal				
			IF FEMALE:	23c. If yes, outcome	of progner	201					1	
Вох	The law requires that the death certifing the has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗀 Fetal	death 3□	Ectopic pregnancy Other (specify)	у		2	3d. Date of deli Month	very Day Year
P.O.	t the c by the ached	hysi	1 ☐ Yes 2 X No 9 ☐ Unknown	9 ☐ Unknown			- (speed)) =					
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ěc	e law r has be e 2 sh	Completed	longs	ran Cl	rle	278	Juse	are	24a. Was autop	osy	prior to c	topsy findings available completion of cause of
al F	sician: The certificate rector, pag-	Co	Du	rueli		•			perto 1 □Yes	rmed? 2 No	death? 1 ☐ Yes	2 □No
Z.	Physician: r this certifica ral director, p	Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☐ No	Hospital:			3 DOA Othe	26. Place of Dea				
οĮ	g Phys er this eral dir	7: To	1 Yes 2 No 27. Manyrer of Death	28a. Date of Inju	ıry	R/Outpatient 28b. Time of	28c. Injur	4 LI Nursing H	ome 5 ☐ Resident Res			cify)
ion	nding F ath. r: After e funera	atio	1 Natural 5 ☐ Pen- 2 ☐ Accident inve	ding (Month, Da stigation	y, Year)	Injury		₹? Yes 2 □No				
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To		Id not be 28e. Place of Injustration			et, factory, office		28f. Location (3 City or Tox		l Number or Ru	ral Route Number,
	Hospita 4 hours Funeral ely fillec	ledical C	(Check only & Medic	ying Physician: To the best al Examiner: On the basis o	of my know	/ledge, death	occurred at the tir estigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s)	and manner as place, and due	stated. to the cause(s)
	ithin 2 o the	Med	one) 29b. Signature and title of cert	and manner sta	ated.		29c. License	e number		29d. Date	e sigped (Mopth	n, Day, Year)
	- s ⊢ ō		1	alina		*	0.	307/	6	111	1,10.	G
1	10		30. Name and address of pers	on who completed cause of d	leath (Item	23a) (Type, F	rint)	1 8	· /11	,44	110	/
14	- W		James 1	AHYENI	1 03	001 7	HISDITA	1/ DR	. Ch	O VI	1/4/	no 20785
	Sta Registr		31. Date filed (Month, Day, Yea		ars Signati	back	1					

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	1- Re	For State Constitution of Certificate gistrar Decedent's Name (First, Middle,Last)	of Death	Reg. N 2. Date of Death	3. Time of Death					
Physician/ ledical Examine	•	JOSEPH R. PELHAM JR.		Month Da November 3,	y 2009 1505 hrs					
1	4	Facility Name (if not institution, give street and number) 3824 Hallaway Circle	4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death Prince George's					
Funeral	- 1	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth (M	MM/DD/YYYY) 9. Birthplace (State or Foreign Country)					
Director		574-78-1858 ₁ X _M ₂ F 52	Yrs. Montels Days Trouts Milita	4/20/19						
d d		sual Residence of Decedent la. State 10b. County 10c. City, Town or L			10 d. Inside City Limits 1 X Yes 2 No					
death with the Maryland or items 23a or 28a-f show must be notified at once	5		RMARLBORO T10f. Zip Code	10g.	Citizen of What Country?					
the Maryland a or 28a-f sh tified at once	5 1 E	De. Street and Number	<u> </u>	"	NITED STATES					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. The Maryland of the standard of the stand			20772. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.					
or items 23		Never Married 2 Married Armed Forces?		Rican, etc./	Specify: BLACK					
ural",	≥ -	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	Yes 2 X No specify: edent's Usual Occupation (Give kind of		Sb. Kind of Business/Industry					
72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use ret	ired)	PRIVATE					
5-0036 iled within 72 Hygiene 1 other than the Medical	틸	12th	ENTREPRENEUR 18 Mother's Name	e (First, Middle, Mai	den Surname)					
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after the pernit regress 1 and 2 should be filed within 72 hours after Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	۲ ۾	7. Father's Name (First, Middle, Last) OSEPH R. PELHAM SR.	EDITH	I PINK	NEY_					
212 ould be d Ment s mark tic ever	9	9a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or RENA RD #102	Rural Route Numbe	er, City or Town, State, Zip Code)					
MD nd 2 sh alth an em 27 i	_ L	OSEPH C. COVINGTON/SON 450	isposition (Name of cemetery,		20c. Location - City or Town, State					
Ore, ges l a t of He l Hite		Burial 2 Cremation 3 Removal from State crematory	or other place)	l-11 - 09	Clinton, Md.					
Baltimore, bermit. Pages 1 ar Department of Hes Important: If ite injury or other tr	-	Donation 5 Other Specify: Resurre	1		rtuary, Inc.					
Dep Dep Inju	- î	Maria Mour Valler	1425 Maryland Ave	NE W	ash., DC 20002 shock or heart Approximate Interval					
Physician / Loical		Ga. Part I. Enter the dise se or complications that caused the death. Do not e failure. List only one course on each line.		or respiratory arrest	Between Onset and Death					
aminer	Ì	Immediate Cause (Final Isease or condition resulting in death) Narcotic (morphine) intoxication Due to (or as a consequence of):								
	Sequentially list conditions, b.									
	<u>a</u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
cuted and transit	Examine	Disease or injury that initiated avents resulting in death) Last d.								
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Box 68760, te death certificate be ex the attending physician the attending physician ted for use as the burial		F FEMALE: 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregi		23d. Date of delivery Month Day Year					
certification of the certifica	cian	past 12 months? 4 Pregnant at time of death 5	Other (Specify)							
Boy ie death the att	Physi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting i	the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?					
of Vital Records, P.O. Bing Physician: The law requires that the defer this certificate has been signed by the uneral director, page 2 should be detached	β	Part II. Other significant conditions contributing to death but not resulting to	The disconying cases given as the	1 Yes	2 No 3 Probably 4 V Unknown					
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of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should be	d d			perform 1 ✓ Yes 2						
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n of iding P h. : After e funer		1 Natural (Month, Day, Year)	unk							
Division tal or Attendii rs after death. al Director: A led in by the fu	ficat	2 Accident Investigation 28e. Place of Injury - At home, far	28f. Location (Street and Number or Rural Route Number, City Upper, State) 3024 Hallaway Cir Upper, Mariboro, MD							
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director. After this certif etdy filled in by the funeral director.	Certification:	4 Homicide determined (Specify) residence								
Division of V To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place, a restigation, in my opinion, death occurre	and due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)					
To the within 2 To the complet	Medical	and manner stated 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
	_	Column	O.C.M.E.		November 4, 2009					
N		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
1										
St: Regist		31. Date filed (Month, Day Year) NOV 1 3 2009 August 32. Registrar's Signature	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PM 2009 6:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Banview Medical Center Itimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min JUA. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☑No Director BALTIMORE DUNDALK 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 2056 KELMORE RD U.5A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No 'natural", or Specify. 2 3 Widowed 4 Divorced WhITE Completed d other than "nature event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than "r. r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) TOO & DYE Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PERKINS EDISION ပ္ ENNI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA PERKINS Health e permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. 2506 KELMORE RD. DUNINGK, M.D. Z1222 ace of Disposition (Name of Date 20c. Location - C 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State W. ARUNDE CREMATORY 11-12-09 ODENTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) daugherty Funeral Home 2601 MOUNTAIN RD. PASADENA, MD. 21122 Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause ar caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rastroint emorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed (es 2 No 1 ☐ Yes Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center, 4940 Eastern Ave, Baltimore, MD 2124 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, 2009 **Physician** Opa1 June Quattrociocchi 0050 M October /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mary (And Hospital Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 23, 1925 9. Birthplace (State or Foreign **Funeral** 1□M 2\ F Days Hours West Virginia Director 234-36-2235 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland | Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Pates Drive 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give Specify: ò Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mother/Housewife At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fili trnent of Hea'th and Mental H tant: If Item 27 is marked oth Albert Alonzo Baumgardner Lucinda Parrish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Quattrociocchi/Son 19000 Poplar Ridge Rd. Brandywine, MD. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11/9/2009 | Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee ale 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one fause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rotht Hop Fracture **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Fall at Sequentially list conditions, if any leading to mind cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed My elodysplastic Diseas
Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2ÆNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 □ Yes 2 □ No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner?
1☐165 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred for at home going to bathroom 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 5 Pending investigation October 29,2007 11:45 M 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicîde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Home 24 hours a Hospital Werkenter 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Solvador Sylvester

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

3001 Hospital Drive Chevenly

29d. Date signed (Month, Day, Year)

09-08269 David Robinson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vid Robinson		State of Maryland / Department of Certificate of		giene Reg. No. 2	009 3717				
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death				
edical Exami	iner	DAVID ROBINSON	A Color Town of Dooth	Month Day Year October 24, 2009	1721 hrs				
		4a. Facility Name (if not institution, give street and number) Wooded area near 2310 Ewing Avenue	4b. City, Town, or Location of Death Suitland	Prince Ge					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		g. Birthplace (State or Foreign				
Director		219–98–7036 1X M 2 F 29 Yrs		09/05/1980 V	ASHENGTON, DC				
nny		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	ion		10d. Inside City Limits				
ind show a	'n	MD PRINCE GEORGES SUITLAND			1 X Yes 2 No				
215-0036 be filed within 72 hours after death with the Maryland that Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha					
ith the 1 23a or notifie		2523 EWING AVENUE 11. Manital Status 12. Was Decedent Ever in U.S. 13. Wa	20746 as Decedent of Hispanic Origin? (Spr	UNITED ST	AMERICAN Indian, Black,				
death wi or items	Funeral		es, specify Cuban, Mexican, Puerto I						
after d al", or	by Ft	3 Widowed 4 X Divorced If Yes, Give Year 1	Yes 2 X No specify:	Specify:	BLACK				
hours 'natur Exami			nt's Usual Occupation (Give kind of w nost of working life. DO NOT use retin		ness/Industry				
36 hin 72 e. than ^e	Completed		L CLERK	POSTAGI	E COMPANY				
1215-0036 Id be filed within 72 hou tental Hygiene. narked other than "nati		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	DAVID WILKINSON ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or R	FEREBEE Sural Route Number, City or Town.	, State, Zip Code)				
O ga P is in	욘		EWING AVENUE, SU						
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or of	sition (Name of cemetery, ther place)	Date 20c. Location - 0	City or Town, State				
Baltimore, permit. Pages I at Department of He Important: If ite		4 Donation 5 Other Specify: RESURRECT	TION CEMETERY 11/	06/2009 CLINTO	N,MD				
Baltimore permit. Pages Department of I Important: If i		220 Signature of Funeral Service Licensee 7TH ILYDIA C. THORNION JOHNSON MOO583 34	Name and Address of Facility IORNTON FUNEBAL 139 LIVINGSTON RO	OME, INDIAN HEAD	, MD 20640				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.			rt Approximate Interval Between Onset and				
/Medical xaminer		Immediate Cause (Final disease a Multiple Gunshot Wounds							
		or condition resulting in death) Due to (or as a consequence of): b.							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
=	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funnata Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u> = </u>	d d							
30, te be exe sysician	ledical			23d. Date of	delivery				
Ox 68760, leath certificate be attending physici for use as the buri	/sician/M	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna	ancy Month	Day Year				
Box (e death ce the attenued for use	ysici	4 Pregnant at time of death 5 C	Other (Specify)						
O. E at the c d by the stached	, Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contril					
S, P.O. Lires that the signed by d be detach	ed by				Probably 4 Unknown Vere autopsy findings available				
tal Records, cian: The law requir certificate has been s ector, page 2 should l	Completed			autopsy p	rior to completion of cause of eath?				
Rec The licate h	L OS		26.Place of Death (Check	1 Yes 2 No 1	✓ Yes 2 No				
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital: 4 Inpatient 2 ER/Outpatient	Other: Scene						
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ion (tending eath. Ithe fur	atio	2 Accident Investigation Oct 24, 2009 1715 hrs	1 Yes 2 ✔ No						
Division tal or Attendin rs after death. al Director: Aled in by the ft	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and Number or Town, State) Wooded area near 2310 Ewi					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide	surred at the time, date and place, and						
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death occurred	at the time, date and place, and d	ue to the cause(s)				
- F E E S	₹ §	29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)				
		Lamely Vuethall, MD	O.C.M.E. October 25, 2009						
		30. Name and address of person who completed cause of death (Item 23a) Pamela E, Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	State								
Regi		NULLY (1 to 1000 12)	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Time of Death Year **Physician** 10/28/ 2009 1430 WILLIAM FITZGERALD REYNOLDS SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE 'S GEORGE"S CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 1**X** M 2□ F 2/4/1964 Washington, DC 45 579-82-3732 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 4326 Douglas Street NE 20019 United States 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic even. Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward Reynolds ဂ Nellie Lucille Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl Reynolds Small Sister 511 Rhode Island Ave. NE Washington, DC 20001 Baltimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page: Department o Important: If any injury or 11/6/2009 Westfield, NC Reynolds Memorial 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Lice Pike Forestville, Maryland 20747 commono 5538 Marlboro Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying su shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician**) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗀 No 1 ☐ Yes 2 🗆 No 1 ☐ Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Marmer of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Qertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Exeminer: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month Day, Year) 29c. License number

State Registrar 30. Nar

32. Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OC7 Year **Physician** STALLINGS JAMES 2009 1355PM 3Ó /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner OLNEY MONTGOMERY MONTGOMERY HOSPITAL GENERAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 2 M 2 □ F 237-66-0757 Director 64 NC Mar. 13, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 28a-f sh 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? items 23a or 3 3227 Bel Pre Rd. 20906 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces r

NYes 2 No 1966filed within 72 hours after 1 X Never Married 2 ☐ Married 9 event, the Medical Examin altimore, Maryland 21215-0036 1 □Yes 2 X No ģ Specify 3 Widowed 4 Divorced Year or Dates: Black "natural" 1972 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled Military 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file trainent of Health and Mental H tant: If Item 27 Is marked oth Be ပ James Stallings Mary Lillie Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau 3009 Southern Ave #11 Temple Hills, Md. 20748 Stacey Washington - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 11-10-2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD. 22, Name and Address of Facility Marshall's Funeral Home of Maryland 21. Signature of Funeral Service Licensee eclarine 4308 Suitland Rd. Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final KLEBSIELLA WITH SEPSIS **Physician** CYSTITIS DAYS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed YPERKALEMIA physician and the burial-trans Box 68760, ACUTE FAILURE RENAL Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. I Tyes 2 TNo certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ METABOLIC ENCEPHALOPATH) 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed VENTRI CULO MEGALY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 **1** No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59418 OCTOBER 30,2009 > Cewserkur, NID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTGOMERY GENERAL HOSPITAL ADEWUNMI, OLUYEMIS! MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2009 Registrar

DHMH 17 Rev 1/2001

Schram,

Baltimore,

Division of Vital Records. P.O. Box 68760.

State Registrar 31. Date filed (Month.

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	Physicia	an	Decedent's Name (First, Middle, Last) MARY F . SCOTT				Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Novembe	4c. County		12:30P M
فمريا	Examili	eı	3346 Cedar Church Road		Darlir			Harf	ord	
h	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 1 1 1 M 2 1 1 7 Age (In yrs 7 7 7 7 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. <i>last birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) 5 / 2 0 / 1	^(ear) 932	Coun	lace (State or Foreign try) J inia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits
	Maryi I-f sho	tor	MD Harford	Bel A:	ir					1 □ Yes 2X No
	or 288	Director	10e. Street and Number		10f. Zip Code		10g	g. Citizen of V	What Coun	try?
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39	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Ever Irant rough be prediffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in I Armed Forces? 1 □ Yes 2 □ ▼ Oli Yes, Give Year or Dates:	I .	<i>Wa</i> s Decedent of Hi f Yes, specify Cuba 1 □Yes 2 <mark>X</mark> No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	Rican, etc.)		ck, White, e	
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ylar	should be and Menta s marked umatic e	10	Robert H. Holdaway				E. Goss			
Mar	d 2 sh Ith and Ith and 27 is m traum		19a. Informant's Name/Relationship (Type. Print) Robert B. Scott, Jr./Son	1	ng Address (Street a Cedar C					MD 21034
	ges 1 and nt of Health if item 27 or other to		20a. Method of Disposition 20b.		sition (Name of natory or other place			Oc. Location -		
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89	ertifica ing ph e as th	Medi	IF FEMALE:				-			
Вох	eath ce attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregion in the past 12 months? 25c. If yes, outcome of pregion in the past 12 months? 25c. If yes, outcome of pregion in the past 12 months in th	tal death 3 □	Ectopic pregnancy Other (specify)	у			ite of delive onth	ery Day Year
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Records, 1	uires tha n signed ld be dei	by	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		icco use cont : 2 ☐ No	tribute to th 3□ Prob	ne cause of death?
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Vital	sician; certifli rector,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 X No Hospital: 1 □ Inpatient 2	7.500:	Othe	26. Place of Deat	h <i>(Check only one)</i> ome 5 ☐ Residen	· Max	Resi	dence
10	g Physical this seral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	IL 3 DOA		ome 5 ∐ Residen 28d. Describe how			//SON'S
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_	To the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death. To the Funeurs after death. To the Funeurs after death. Completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physiclan: To the best of my kir and manner stated.							
	To the within 3	Mec	29b. Signature and title of certifier		29c. License		290	d. Date signe	ed (Month,	Day, Year)
			Mulling up.		DL	15921	N	OVER	1BER	9,2009
	14		30. Name and address of person who completed cause of death (Ite	7 020	EMMO	ATON K	20 Suit	- è 2-	-i) -	21050 BEL Am
I	Sta Registr		31. Date filed (Month, Day, Year) Seven 32. Registrar's figure 1.	ature and	1					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 **Physician** 8:00 PM Pauline Taylor 31 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Taney Village Apt. Frederick Frederick 416 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/8/1921 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2**X** F Yrs. 88 Maryland 213-18-8403 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location r then "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1XYes 2 No Funeral Director MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1421 Taney Village Apt. 416 21703 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then Hygiene. School Bus Driver Fred. Co. Schools 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any light of other traumatic event once. 17. Father's Name (First, Middle, Last) George Taylor Ora Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31 E. Orndorff Dr. Gail Miller, Niece Brunswick MD. 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/5/2009 Samples Manor Cem. Sharpsburg, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of partific who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Deneus Registrar

Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3<u>0</u> **Physician** 3:50 P M OCTOBER 2009 MARY J. TYLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 4209 28th STREET MT. RAINIER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ XF MARYLAND **Director** 577-54**-**0658 78 AUG 16 1931 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanting 1. ust be retified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Director PRINCE GEORGE'S MT. RAINIER MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4209 28TH STREET 20712 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1∐Yes 2∏No Specify Specify: 3 Widowed 4 Divorced BLACK Be Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GOVERNMENT FOSTER CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MELVIN PROCTOR MARY SWALES ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE TYLER/HUSBAND 4209 28TH STREET MT. RAINIER, MARYLAND 20712 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 11/6/2009 BRENTWOOD, MARYLAND J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Fuheral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MALIGNANT NEOPLASM ASCENDING COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician the use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo ō Month Day Year 5 ☐ Other (specify) the should be detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐Yes 2 🔯 No 1 ☐ Yes 2 🔀 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) 466666

State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

	8666 neth Taylor		St	oe or Print in B ate of Maryland	/ Departme	ent of	Healt	h and	All Co	opies al Hyg	Are Legi iene		200	9 3	718
			- For State Registrar		Certifica	ate of	Death	7		12	Reg. Date of Death	No.	200	3. Time of De	
	Physicia		1. Decedent's Name (First, Middl	e,Last) .						1		ay 2000	Year	1845 hrs	
Me	dical Exami		Kenneth Taylo	or			b. City, To	own or L	ocation of		ADVerriber 7		nty of Death	<u> </u>	
•			4a. Facility Name (if not institution 8823 Welbeck Way	n, give street and number	'}		Burtor	13ville N	lonta	OMAT	y Villa	Monte	gomery		
			5. Social Security Number	6. Sex 7. A	ge (In yrs. last birt	hday)		r 1 Year	If Under	24Hrs. 8	B. Date of Birth	(MM/DD/Y	YYY) g. Bir	thplace (State	or
	Funeral Director	- 1			54		Months		Hours	Min.	12/10/1	.954	Foreig	ountry) FL	
	Director	ļ	267-13-9658	1 X M 2 F	74	Yrs	·				<u> </u>	, ,,, ,			
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County	Montgomery	10c. City, Town	or Locati	ion							10d. Inside C	
	3:		MD Monto	gomery	Gait	nersi	oura							1 X Yes	2 No
-	he Maryland or 28a-f show ified at once	Director	10e. Street and Number	<u> </u>			10f, Zip	Code			100	. Citizen o	f What Cou	intry?	
32	or 28	ä	8823 Welbeck W	lay				2088	36				AZU		
5	vith tl s 23a e noti		11. Marital Status	12. Was Deceder		13. Wa	s Decede	nt of Hisp	anic Origi	n? (Spec	ify Yes or No-		Race - Amer	rican Indian, Bl	ack,
1	eath v item ust b	Funeral	1 Never Married 2 N	Armed Forces	s? 2 No	l If Y	es, specif			Риепо К	can, etc.)	1		a =1.	
	fler d		3 Widowed 4 X Div	vorced If Yes, Give Year	172-1.9AA	1	Yes 2					Spec	,	lack	
	ours a	d by	15. Decedent's Education (Spe	ecify only highest grade co		Deceder	nt's Usual nost of wor	Occupation	on (Give k	ind of wor		16b. Kind o	of Business	/Industry	
	72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 o								_			
	5-0036 Led within 7 Hygiene. I other than	Ę.	12			Kara	<u>te Ir</u>	<u>ıstru</u>	ctor	a Nama (E	irst, Middle, M	Ser aiden Sum	vice	 	
	5-0 iled v Hygiv 1 othe		17. Father's Name (First, Middle								M. Bar)		
	121 d be finental l arked	Be	James E • Tayl 19a. Informant's Name/Relation		110	h Mailin	n Address	S (Street			ral Route Numl		Town, Stat	te, Zip Code)	
	D 21 should and Mer	J.	Crystal L. Fo								usby M				
	MD and 2 sho salth and 2 is em 27 is raumat		20a, Method of Disposition	ru/ vaugi icei	20b. Place	of Dispo	sition (Nar	me of cen			Date	20c. Loca	tion - City o	or Town, State	
	of He		n 3 Removal from			ther place		ODU	1.1./1	.2/2009	Rel	tsvi1	le, MD		
	Lim Pag ment tant:	ŀú	4 Donation 5 Other S		Ches	apear	Viame and	Address	of Eacility					ervices	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y 117	21. San ture of Fun fr Say o	Licensee	/	12.		1100	toun	201-	Camp	nuie Sprin	ası M	D 20748	
	Physician		2 a. Part I. Enter the disease, of	or complications that cause	ed the death. Do	not enter	the mode	of dying,	such as c	ardiac or r	espiratory arre	st, shock,	or heart	Approxima	nte Interval Onset and
	Physician di al		failure. List only one caus	e on each line.											eath
	taminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a con		ensi	ve ca	iluic	vasc	GTGI	QISCUD				
			Sequentially list conditions,	b										_	
		ner	if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a cor	nsequence of):										
		xamine	(Disease or injury that initiated events resulting in death) Last	C	nsequence of):		_	_							
	nted d ansit	ΙШ	events resulting in death) Last	d.											
	760, icate be executed physician and the burial - trans	sician/Medical	X UNPENDED	X AMENDED 2	3a,27,pe Jb, per l	TOPIN	л <mark>8</mark> 898	3 12	<i>21</i> 49	9 TT	•				
	60, ate be hysica e buri	Med	IF FEMALE:		come of pregnance								ate of deliv		V
	587 ertifical	an/	23b. Was decedent pregnant in past 12 months?			_	etal death		Ectopi	c pregnan	icy	Mo	nth	Day	Year
	Box 68760 he death certificate by the attending physined for use as the bu	sici	1 Yes 2 No 9 U	nknown g Unknown	t at time of death	5 (Other (Spe	ecify)							
	O. B. trthe de by the	≘	Part II. Other significant cond			ing in the	underlyin	ng cause	given in P	art I.				to the cause of	
	P.O s that t gned by e detac	<u>a</u>	T use in outside and			-					1 Yes	2 🗸 N	o 3 P	robably 4	Unknown
	ords, P.C. w requires that as been signed to should be deta	E E									24a. Was			autopsy findin	
	ord aw rec as bee	e										rmed?	death		_
	Records, The law requirefficate has been signated by	Completed									1 🗸 Yes	2 No	1 🗸	Yes 2	No
	al Fian:	Be	25. Was case referred to medi examiner?	Linenitel					e of Death			Posidono	6 4 0	ther: Scene	
	Division of Vital Reconstance and Vital Reconstance and the law and predefined and an objector. After this certificate has led in by the funeral director, page 2 s	2	1 ✓ Yes 2 No			Outpatie b. Time o		DOA 128c Init	ury at Wor		Home 5 28d. Describe				
	of ing P	=	27. Manner of Death 1 X Natural 5 Pe	28a. Date of (Month, D.		u. Tillie u	ппрагу		Yes 2	_ I					
	sior trend death	j	1 X Natural 5 Pe	ending vestigation	of Injury - At home	form **	reat facts		-		28f. Location (Street and	Number or	Rural Route N	umber, City
	ivis lor A after of Direction by	Certification:	3 Suicide 6 Co	bula not be	or injury - At home	, rarm, st	eet, iacto	ny, onice	Dunumy, t		or Town,				
	Division Nospital or Attend 24 hours after death : Funeral Director:	Cer	4 Homicide 29a. Certifier 1 Certifying	Physician: To the best of		doobt ==	nurrod of th	ho timo	tate and n	lace and	due to the cau	se(s) and r	manner as	stated.	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in which fineral director, page 2 should be detached for use as the burial - transi	E E		Physician: To the best of xaminer: On the basis of	or my knowledge, examination and/	oeatn oct or investig	gation, in r	my opinio	n, death c	ccurred a	t the time, date	and place	, and due t	o the cause(s)	
	To the within To the Comple	Medical	29b Signature and title of cert	and manner stat	ted				se numbe					(Month, Day, Ye	ar)
				. 1			1								

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD.

State 31. Date filed (Month, Day 2009)

OCME

November 8, 2009

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Claure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Novemba Arthur Woodring Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 21, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F 73 Months Days Hours Min 209-28-9457 Director Pennsylvania Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17600 Meadowood Drive 21740 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give should be filed within 72 hours aff and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Woodring Alice Keckler permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Woodring/Wife 17600 Meadowood Dr., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🌠 Cremation 3 🗆 Removal from State Smithsburg Crematory | 11/14/2009 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service icensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure, List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw rval Betv Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or impury that initiated events and -trans Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' the Funeral Director: After this certificate mpleted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to med Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No ၉ 1 🖺 Inpatient 2 🖼 ER/Outpatient 3 🗌 DOA 27. Manner 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending death. Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

egistrar's Signatur

DHMH 17 Rev 7/2009

10

DX

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SUIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sylvia Allen Gilchrist 1. For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0729 hrs November 16, 2009 Sylvia Allen-Gilchrist Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County Pikesville 3800 Old Court Road #221 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Country)Tennessee Min. October 19,1938 Months Days Hours 419-50-8951 71 Director M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 X Yes 2 No Gwynn Oak Baltimore City Maryland 28a-f show notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21207 2806 Silverhill Avenue 喜 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X No Yes Specify: Black 4 X Divorced If Yes, Give Year Yes 2 X No specify: Widowed hours after Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) 5+ Elementary/Secondary (0-12) pe mit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 injury or other traumatic event, the Medical E Public Education Teacher 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sevelia Blackmon Elias M. Webb Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melbourne, Florida 32935 2429 Apache Drive Baltimore, MD Josef Allen 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition November 19. crematory or other place) 2 X Cremation 3 Removal from State Burial Baltimore, Maryland 2009 Metro Crematory Donation 5 Other Specify ²² Name and Address of Facility Cremation Society of Maryland 299 Frederick Road Baltimore, 21 Signature of Funeral Service Licensee Maryland, Inc. altimore, Maryland Alice Iser 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 ✓ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown þ Congestive Heart Failure Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 ✓ Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be Other-Residence 6 Other: Scene examiner? Hospital: 1 DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes No

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, this After 124 hours after death.

Funeral Director: A ctely filled in by the fu To the

27. Manner of Death

Accident

Suicide

Homicid 29a. Certifier

5

Pending Investigation

Could not be

1 V Natural

Certification:

Medical

State

Registrar

2

3

(Check only

and manner stated 29b. Signature and title of certifig

(Specify)

28a. Date of Injury (Month, Day, Year)

November 17, 2009 O.C.M.E

or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

28c. Injury at Work?

29c. License number

Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Patricia Aronica-Pollak MD.

32. Registrar's Signature 31. Date filed (Month, Day, Year,

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

experie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 Birkelien Charles Ε. November 12:10 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye August 7 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □**X**M 2 □ F Maryland **,**1933 76 Director 218-28-1675 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 USA 2411 Oak Manor Road permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 XYes 2 □ No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Shipping Clerk Steel 11 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gustav Birkelien Ida Simonsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21219 2411 Oak Manor Road, Edgemere, Maryland Genevieve Birkelien wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 18, 2009 21. Signature of Funeral Service License ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canco MAG disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonay Obstructive 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.

Funeral Director: After this certificate has autopsy performed Yes 2 X death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Yes ဥ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

N. Charles St

2149194

Towson.

MD

91204

November 17, 2009

(RWP

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

1ani

Marian Grant

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9897 11-24-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <u>4:00 Р</u>м Lillian Brassen Lillian Bassen 2009 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville Oak Crest If Under 1 Year If Under 24 Hrs 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 🛛 F Months Hours 051-24-3924 **Director** 97 1912 New York June Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Parkville Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 8810 Walther Blvd., Apt. 1528 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 X No ۵ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) <u>Administrative Assistant</u> U.S. Government permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ethel Brenner Issac Pressman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Bassen / Son 20815 3505 Hutch Place, Chevy Chase, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 11/21/2009 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signa 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ basal ganslia disease or condition resulting in death) Medical Due to (s a consequence of): Examiner Sequentially list conditions, if y leads to cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by edering 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cerebral Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 욘 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parhaille MD 4234 Elosha

State Registrar Date filed (Month, Day, Year)

200

Bassen

Lillian

egistrar's Signature

Physic		For State Registrar		C	ertificate of		Reg	. No.	3. Time of Death
FIIYSIC	ian	1. Decedent's Name (First, Middle, L Violet Elizabet						[□] 1 ^y 9, 2ŎÖS	6:15 A M
/Medi		4a. Facility Name (If not institution, g			Ab City Town o	r Location of Death	. TO V CALLOCE	4c. County of Dea	
Exami	ner	Franklin Woods N		r	Rosedale			Baltimor	
Funeral				In yrs. last birthd	(ay) If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	9. Bi	rthplace (State or Foreig
Director		233-44-3898	1 □ M % ▼ F	81 Yrs	Months Days	Hours Min.	Month, Day, Y 09/07/19	28 Wes	st Virginia
	1	Usual Residence of Decedent		o- City T	-1				40d Inclide City Limit
show d at	_	10a. State 10b. County Maryland Baltimo		Oc. City, Town or Middle					10d. Inside City Limit
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show yn Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1110010			100	J. Citizen of What C	
a or 2	ä	10e. Street and Number	-		10f. Zip Code	20	109	U.S.A.	outiny:
is 23	eral	833 Lannerton Roa	12. Was Decedent Ev	er in U.S.	212:		ify Yes or No-	14. Race - Am	erican Indian,
iner	ᇤ	1 Never Married 2 Married	Armed Forces?		13. Was Decedent of H If Yes, specify Cuba		ican, etc.)	Black, Wh	ite, etc.
al", ol Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XXX No	Specify:		Specify:	White
ical E	Completed by	15. Decedent's (Specify only highest of	Education	16a. De	ecedent's Usual Occup	ation	16	b. Kind of Busines	s/Industry
e. Med	uple	Elementary/Secondary (0-12)	College (1-4or 5+)	'iii	rive kind of work done fe. DO NOT use retired	d)		7.7	
er th	S			Tea	cher			Education	
d oth even	Be	17. Father's Name (First, Middle, La. Bryan Glover	st)			18. Mother's Name (iden Surname)	
arke	은			1			-		
ism		19a. Informant's Name/Relationship	,		lailing Address (Street				
m 27		William Baker (Hu 20a. Method of Disposition	isband)		Lannerton			Oc. Location - City of	
0 = 0		1 X Burial 2 ☐ Cremation 3		cemetery,	isposition (Name of crematory or other place	ce)		•	e, Maryland
rtant Jury	. 8	4 Donation 5 Other (Spec		HOTTA H					
mpo iny li	1	21 Si Fature of Fu	Nansee		BY	ss of Facility UZďŽINSKI	Funeral	Home, P.	A. yland 21221
		23a. Part1. Enter the disease, or co	amplications that caused th	o doath Do not					
	15 - 31	shock or heart failure. List on Immediate Cause (Final	ly one cause on each line.				respiratory arres	4	Approximate Interval Between Onset and Death
/sician ledical		disease condition resulting in death)	a	-	MONIA	*			DAY
aminer			Due to (or as a	consequence of):	STROK	KE			
\$	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
ansit	Ë	cause. Enter Underlying Cause (Disease or injury that initiated events							
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use	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2		3 ☐ Ectopic pregnanc	v.		23d. Date of d	*
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		5 ☐ Other (specify) _	у		Month	Day Year
by th	hys	9 ☐ Unknown	9□ Unknown						
T (0)	by P	Part II. Other significant conditions		not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
gne e d	pa k	HYPER	SLENZION				1 ☐ Yes	2 □ № 3 □	Probably 4 □Unknov
en signec ould be d	Completed	<u>_</u>	AD				24a. Was an autopsy	24b. Were	autopsy findings availat o completion of cause o
is been signed by the attending physician and 2 should be detached for use as the burial-transit	E O						performe	ed? death	2
has le 2		25. Was case referred to medical				26. Place of Death	1		
ate has page 2		examiner?	Hospital:	2 ER/Outpa	atient 3 DOA Oth	ner: 4 Nursing Hom	ne 5 🗆 Residen	ce 6 □Other (Sp	necify)
ate has page 2	Be	1 ☐ Yes 2 ☐ No	1 ☐ Inpatient			ry at 2	8d. Describe how	injury occurred	
ate has page 2	To Be	27. Manner of Death	28a. Date of Injury	28b. Tim	re of 28c. inju	(IN:			
ate has page 2	To Be	27. Manner of Death 1 Natural 5 Pending investigat	28a. Date of injury (Month, Day		ıry Wo	Yes 2 □ No			
ate has page 2	To Be	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) Inju		Yes 2□No	8f. Location (Stre City or Town,		Rural Route Number,
ate has page 2	Be	27. Manner of Death 1	28a. Date of Injury (Month, Day) to be d 28e. Place of Injury building, etc.	Year) Inju	M 1 □	Yes 2 □ No 2	City or Town,	State)	
ate has page 2	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Ex	28a. Date of Injury (Month, Day) to be ad 28e. Place of injury building, etc. Physician: To the best of caminer: On the basis of e	y - At home, farm (Specify) my knowledge, coxamination and/o	M 1 1, street, factory, office death occurred at the ti	Yes 2 □ No 2	City or Town,	State) Jse(s) and manner	as stated.
ate has page 2	Certification: To Be	27. Manner of Death 1 Natural 5 Pending investigat 3 Sulcide 6 Could not determine 29a. Certifier (Check only one) 1 Medical Expansion (Check only one)	28a. Date of Injury (Month, Day viole) 28e. Place of injury building, etc. Physician: To the best of	y - At home, farm (Specify) my knowledge, coxamination and/o	M 1 □ I, street, factory, office death occurred at the tion investigation, in my	Yes 2 □ No 2 ime, date and place, a opinion, death occurre	City or Town, and due to the cau ed at the time, da	State) use(s) and manner te and place, and d	as stated. ue to the cause(s)
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To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person wh	28a. Date of Injury (Month, Day) 28e. Place of injury building, etc. Physician: To the basis of a and manner state	Year) Inju y - At home, farm (Specify) my knowledge, c examination and/o	M 1 1 death occurred at the tipe investigation, in my 29c. Licens	ime, date and place, a opinion, death occurre se number	City or Town, and due to the cau ed at the time, dat	State) use(s) and manner te and place, and d	as stated. ue to the cause(s)

4a. F Examiner 6 5. Sc **Funeral** 21 Director Usua permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. **Funeral Director** Ma 10e. 1 RAYMOND E. BLACK 11. N Completed by Baltimore, Maryland 21215-0036 3 Be 17. F ည 19a O] 20a. 21. 23a lmr dise Pnysician/ Medical Examiner Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 IF FI been signed by the attending should be detached for use 23b Part

For State Registrar

Physician/

Medical

1. Decedent's Name (First, Middle, Raymond Eug	Last) rene Blac	ck					2. Date of Deat Month	th Day	200	19	3. Time of Death S: S 5 AM
4a. Facility Name (if not institution,	A 2	pital			Location o			4c.	County of D		
		e (In yrs. last birtho	lay) If Unde	r 1 Year Days	If Under Hours		8. Date of Birth (Month, Day, 12/20/1	944	g. Pe	Birthpla Country	ace (State or Foreign y) ylvania
Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	or Location			_				110	d. Inside City Limits
Maryland Baltim	ore		e Rive	_							1 🗆 Yes 2 🟋No
10e. Street and Number		THUGH	10f. Zip					10g. Cit	izen of What	Countr	
1546 Dornton A	venue			212	220				US	SA	
11. Marital Status 1 ☐ Never Married 2 【XMarr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates.	Ever in U.S. No	13. Was Deced If Yes, spec	cify Cuba	n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:		с.
	t's Education st grade completed)	(0	ecedent's Usu Give kind of wo	rk done c	ation furing most	t of worki	ng	16b. Ki	ind of Busine	ess Indu	istry
Elementary/Seconday (0-12)	College (1-4 or 5)+) 	fe. DO NOT use larpente	,				Co	nstruc	tio	n
17. Father's Name (First, Middle, L Arthur Sai	muel Black	•				er's Name	(First, Middle, M	Лaiden S			
19a. Informant's Name/Relationsh Olga Black (w.	ip (Type, Print) ife)						I Route Number, iddle Ri				
20a. Method of Disposition 1 Burial 2 Cremation			crematory or o	other plac			Date		ocation - City		
4 ☐ Donation 5 ☐ Other (S		Bayview)/2009 uzdzinsk				
21. Sign die of dilazi Service L	, L	`					zuzīnsk zenue Es				
23a Part 1 Enter the disease, o hoc or heart failure. List o Imme, iat. Cause (Final diseas condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to ('r a' b. Due to ('r a') c.	ercap(11C 100 200082	3P1	rate	ry	r respiratory arre				Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	of pregnancy 2 Fetal death t time of death	3 ☐ Ectopic 5 ☐ Other (s _i	pregnanc oecify)	÷у				23d. Date of Month		y Day Year
Part II. Other significant condition											cause of death?
Chronic Obstru	ctive form	anary l	71,2692	e,	rnec	mo	1 🗆 Y	es 2	□ No 3□	Proba	ably 4 Unknown
nia, Pulmona	ary Embo	olism					24a. Was a autop perfor 1 \(\supersection\) Yes	sy med?	prior deat	to com	sy findings available pletion of cause of
25. Was case referred to medical examiner?	Hospital:				ace of Dea	th (Check	only one)				
1 ☐ Yes 2 ☑ No 27, Manner of Death	1 Inpati	ent 2 ER/Outp		_	4 ∐ Nı		me 5 Resid			pecify)	
1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investig	g (Month, Da			28c. Injur work 1 🗆	yaı :? Yes 2. □		28d. Describe ho	ow injury	y occurred		
3 Suicide 6 Could 4 Homicide determ	not be	ury - At home, farm c. (Specify)					28f. Location (Si City or Town			Rural F	Route Number,
(Check 2 Medical E	Physician: To the best of xaminer: On the basis of a Nurse Practioner: To the	xamination and/or i	investigation, in	my opinio	on, death o	ccurred at	the time, date ar	nd place	, and due to	the caus	se(s) and manner stated.
29b. Signature and title of certifier	MENUCCI,			RE	s number			1	te signed (M	200	9
30. Name and address of person v	who completed cause of Q			ARI,	4 ME	NUC	C(5601L	ocl	d Rai	160	Blvd.
31. Date filed (Month, Day, Year)	2009 32 Registr	ar's Signature	barles)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2009

State Registrar

within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s

25.

27.

Medical Certificate: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. Physician/ 18 2009 Lea Raymond P. Bender 1:00p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 🗆 F 235-36-2578 83 Director 3. March 1924 Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 1320 Dorsey Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 XNo ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Steel Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Ernest Bender Florida Cougar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per mit. Page 1 and 2 sh Def artment of Health ar Important; If item 27 is any injury or other trau 1320 Dorsey Avenue Baltimore MD 21221 Cynthia Bender /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remeter, cremator, or other place)
Holly Hill Cemetery 11/21/09 Baltimore MD 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 300 Mace Ave. Balto. MD K Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lancer una months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical | MO/ND s, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ☐ Pregnant at time of death in the past 12 months? Month Day Year the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pulmonary Obstructive 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementio has autopsy performed? Yes 2 X No 1 Yes 2 No certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital

State Registrar 29a. Certifier (Check

Vovember

3

29b. Signature and title of certifier

anan

N. Charles 6701 32. Registrar's Signature

CRNY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Towson,

R149194

29d. Date signed (Month, Day, Year)

MD 21204

November 18, 2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Perate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARY 2079 111, /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner RANDALLST BALTIMORE NOOTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🗹 F Months Days Hours 71 490-40-9170 Usual Residence of Decedent Yrs Aug 27 Director Missouri permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Modical Exprendictory mast be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No by Funeral Director Baltimore Owings Mill, Maryland MO 10g. Citizen of What Country? 10e. Street and Number U.S.A. 205 Cedarmere Circle 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlie Coleman ပ Shallie Hoye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Cedar mere Circle Owings Mills, MO 21117 Shaille J. Bryant/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wood Lawn, Cemetery Nov. 21,2009 22. Name and Address of Facility
Runcild 1. Grayin Fineral Service
270 FRED if it for the special march 21249 21. Signature of Funeral Service Licensee Renald a. Mayar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIDYASTULAR DISEASE Immediate Cause (Final ARERIDSCLERMIL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUN6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should the completely filled in by the funeral director. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide PSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00024970 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 RANDALLS RUAD FABER DLO COURT

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 1 & ZUUS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 3 35 AM GEORGIA ELIZABETH BEARD 2009 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore FRANKLIN Square Hospital Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Apr. 3, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔼 F 1944 Director 217-40-1429 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ∏Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 21015 3016 Goat Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed venent of Health and Mental Hygicant; If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph M. Everd Sr. Ruth R. Keller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai 3016 Goat Hill Road, Bel Air, Maryland 21015 E. David Beard / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Memorial Gdn.11-23-09 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License Baltimore, Maryland of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or ∞ shock, or heart failure. List on divious that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Physician SepSiS Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Failure Renal Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) La Houtul M.D. NOVEMBER, 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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that the death certificate be executed

Box 68760,

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Records,

Division of Vital

Hospital or Attending

filed within 72 hours after

Registrar

Kottarathis

John

32. Registrar's signature

9000 FRANKLIN SQUARE DR BALTO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 13, 2009 5:20 Рм <u>Vernon Washington Brown III</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center @ GBMC Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign July 28, Days Year 972 1**XX**M 2 □ F Mafry Pand 37 218-72-3476 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No <u>Marylan</u>d Harford Abingdon 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21009 158 Glenview Terrace 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2XXNo Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Ringgold Vernon Washington Brown Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 9807 Slalom Run Drive, Woodstock, Maryland 21163 19a. Informant's Name/Relationship (Type, Print) Vernon Brown Jr. / Father 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Cem1/21/09 Aberdeen, Maryland Union United Meth. f Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death anadashi disease or condition resulting in death) as a consequence of): Sequentially list conditions. Due to (or as a consequence of) Due to (or as a consequence of):

Physician/ Medical Examiner

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To the Funeral Director: A

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Certificate:

Medical

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that the death certificate be executed

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician; The law requires

Important: If it any injury or o

Physician/

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"natural", or items 23a or 28a-f show edical Examiner must be notified at

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Page 1 and 2 sl ment of Health a tant: If item 27 i

should be filled within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examir that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

25. Was case referred to medical

31. Date filed (Month, Dev. Year)

MUNOU

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Pregnant at time of death 5 Other (specify) g | Unknown

3 Ectopic pregnancy

1 Yes

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Day

Year

23d. Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed' Yes 2 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

examiner?	QNo	Hospita	1 ☐ Inpatient 2 ☐	ER/Outpatient	з 🗆	DOA Ot	ther: 4	☐ Nursing H	ome 5 🗆 Residen	ce 6	Other
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3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	280	. Place of Injury - At he		t, facto	ory, office	Э		28f. Location (Stre		Vumber

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

> 6701 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 7/2009

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	s 23a	ral	12331 Old Frederick Road			21788			S.A.			
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Modical Everither must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi				
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Σ,	and 2 ealth n 27		Marguerite L. Baker/ wife		Willow R			ick, MD 21				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examiner must be notified at ODC9.		20a. Method of Disposition 2 Cremation 3 Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other plac	e) l	Date :	20c. Location - City of	r Town, State			
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<u>at</u>	permit, Depart Import any Inj once.		21. Signature of Puneral Service Licencee	2	2. Name and Addres	ss of Facility Had	rtzler F	uneral Ho	me			
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Ö	tal or A	Certification: To										
	To the Hospital or Attending Physiclan: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier Check only 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, dea nination and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occur	, and due to the or rred at the time, d	cause(s) and manner late and place, and d	as stated. lue to the cause(s)			
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,			30. Name and address of person who completed cause of death	(Item 23a) (Time		016428		1/10	0-1			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November It. 2009 **Physician** 10:15 a.M Brandt Edith Mae /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 27, 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Months Hours Min Mary Land 1 □ M 2 🙀 F 72 Ĩ937 Director 219-32-9943 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ntal Hygiene. ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at 1 ☐ Yes 2 XXVo Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20906 15100 Interlachen Dr. #4-203 Funeral Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify Specify: White 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Contractor Personnel Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental item 27 is marked o Ella Ernstine Kitzmann Chester Louis Brenn ည (daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11305 Cloverhill Dr. Silver Spring, Maryland 20902 <u> Cynthia Brandt - Campagna</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 19 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funding Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Metastatic Cancer of the Gastroesophegeal Junctions **Physician** disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sensequence of: Examiner the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Hospice 1 Yes 2 XNo ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attenda.

14 hours after death.

19 Director: AF

ho the Division Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number J. Koucetchou, mo November 17, 2009 163748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kouatchon, M.D. 201 E. University Parkway, Baltimore, MD. 21218 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 2 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c fft 9897 il 1-30-09 Wt State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year BUTLER LARENCE NOV 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F 70 **Director** 219-26-3213 Usual Residence of Deceden Sept.17,1939Connecticut 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner must be notified at MD n/a 1√2 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3716 Bartwood Road 21215 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Speci**B**lack 3 Widowed 4 Divorced d 2 should be filed within 72 hours the and Mental Hygiene. 27 is marked other than "natural", traumatic event, Ita Mudical Exa Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Retired 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Butler Emma Rice ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and If item 27 is π or other trauπ Hattie Butler (wife) 3716 Bartwood Rd. Balto, Md. 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ______ 20c. Location - City or Town, State ______ Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-2-09 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Cem. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md, 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner may cance Sequentially list conditions, if any, leading to indirectiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ∐ Yes 2 ∐ No is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) # 006810 NOV 10, 2009 00 ya 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE PRISCILLA M. SHOGAN, D.O. SINAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature MON TA STIMA Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) November 16 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 3, 1953 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 56 212-60-8589 Maryland Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show notified at 1 Yes 2 □ No Director N/A Baltimore Maryland with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō ral", or items 23a o Examiner must be 108 North Belnord 21224 Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Small Engine 10 Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glen Bledsoe Hattie Allen ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 3083 Ebbtide Drive Edgewood, Maryland 21040 Darrell E. Bledsoe, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 11/18/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical as ase 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Inpatient 1 ☐ Yes 2 No Hospital: Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 Residence ٩ 24 hours after death.

Funeral Director; After this 27. Manner of Deat 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 □ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) To the within 2 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 FIONA HAVERS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MOA S O Sona

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2009 BROWN 3:05 14 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALMONGRE CITY SILVEL THURNE BAUT 72 D If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212-30-6106 Days Year) 1□M 🐙 F Months Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show 1 Yes 2 No min Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 21.51A Fethorne 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify BIALK ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) Be ပ Am 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Health tem 27 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ricid . CAroline 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dehydretion week /Medical Due to (or as a consequence of): Examiner ندودان sphezin. Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): years physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, requires that the death certificate be Physician/Medical led by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director After 1 Afatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Ken would

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

KIUCSZ

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31. Date files Month, Day, Year)

31255

Balhace

11/18/09

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Jose Chacon 09-08829

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2009 37202

		Registrar				Ce	rtificat	e oi	Dealli					Reg. No.			
Physicia edical Exami	an/	1. Decedent's Na	me (First, Midd	e,Last)	Jo	se	Cha	ac <u>o</u>	n			2	. Date of De Month Novemb	Day er 13, 20			Time of Death 2158 hrs
		4a. Facility Name 5100 blk A	(if not institution in tributus Ave	-	et and nu	mber)		41	D. City, To Baltimo		ocation of	Death		4c. C	ounty of D		
Funeral Director		5. Social Security	Number / a	6. Sex	2F	7. Age (In yrs. 35	last birthd	ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.		Birth(MM/DD -1974			yatemala
	1	Usual Residence	of Decedent													140	d. Inside City Limits
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MD 21215-0036 2 should be filled within 72 hours after death with the Maryland h and Montal Hygiene, Try is marked other than "natural", or items 23a or 28a-f she matic event, the Me Itel Examiner must be notified at once	5	19a. Informant's	Name/Relation:	ship (Type,	Print) N	lephew	19b.	Mailing	Address	(Street	and Numb	per or Ru	ural Route N	lumber, City	or Town,	State, Z	p Code) 21215
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Page:		4 Donation			10/110/0/	P	layi	tas	Cer	nete	ery	11-	28-09	Pla	yita	as,G	Suatemala
Baltimore, MD 21215-0036 Depemit. Pages I and 2 should be filed within 72 hours after Depemton to File and Mental Hygiene. Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	l j	21. Signature of						22. N	ame and A	Address	of Facility	Ma	rch I	East	F/H		127
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Physician		23a. Part I. Enter	the disease, o			caused the dea	th. Do not	enter th	ne mode of	dying, s	such as ca	rdiac or	respiratory	arrest, shoc	k, or hear		Approximate Interval Between Onset and
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Box 68 he death cert the attendir	Physicia	1 Yes 2	No 9 U	nknown			5	0t	her (Spec	шу)							
D. E t the d by the ached	P.	Part II. Other sig	nificant cond	tions cor	ntributing	to death but no	t resulting	in the L	inderlying	cause g	iven in Pa	rt I.	23e. D	id tobacco u	se contrib	ute to th	e cause of death?
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of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	유	1 ✔ Yes	2 No		•	Inpatient 2	ER/Ou		L	<u>٠</u> ٠٠	y at Work		g Home 5	ibe how inju	ry occurre		Scerie
Ing Pl		27. Manner of D			Nov 13	e of Injury th, Day Year) 3, 2009	2141	ime of I hrs	fijury 2		yatwork ′es 2 ✔		Subject s		ry occurre		
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Division hall or Attendir rs after death. at Director: A led in by the fu	Certification:	3 Suicide		uld not be ermined		ice of Injury - A	t home, far	m, stre	et, factory	office b	uilaing, et	- 1	ог Том	on (Street al n, State) Arbutus Av			
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Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attendi	ca	29a. Certifier (Check only one)	Certifying	Physician: aminer:∩r	To the be	est of my know of examinatio	ledge, dea n and/or in	th occui vestida	rred at the tion, in my	time, da opinion	ite and pla , death oc	ace, and curred a	due to the out the out the time, of	cause(s) and late and pla	ce, and du	as stated ue to the	cause(s)
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		30. Name and a						111	Denn	Street	Raltim	ore M	D 21201				
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rl Craig Courtn	1.	- For State Certifi	ment of Health and Mental H icate of Death	ygiene Reg. No	2009 3720
Physicia		teqistrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death 1907 hrs
edical Examin	er	Carl Craig Courtney		Month Day November 12,	2009 1907 TITS
	4	4a. Facility Name (if not institution, give street and number) 5009 55th Avenue	4b. City, Town, or Location of Death Hyattsville	1 (Prince George's
Euporal		5. Social Security Number 6. Sex 7. Age (In yrs. last b		_	M/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		216-58-6985 1xm 2 F 51	Yrs. Months Days Hours Min	09/11/19	
any		Usual Residence of Decedent 10c. City, To. 10a, State 10b. County 10c. City, To.	wn or Location		10d. Inside City Limits
\ <u>}</u>		MD Prince Georges Hyatts	sville		1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
the Man or 2		5009 55th Avenue	20782		USA
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puerto	Specify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
or deat	Ш	1 Yes 2 A No	1 Yes 2 X No specify:		Specify: White
irs afte	화	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of	work done 16t	b. Kind of Business/Industry
72 hound at Exa	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re	tired)	
036 rithin and sene.	림		Disabled	ne (First, Middle, Maid	en Surname)
filed v Hygird oth	ပ္တို	17. Father's Name (First, Middle, Last)		Lee Hayn	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	e Be	John Thomas Courtney 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number	, City or Town, State, Zip Code)
MD and 2 shoulth and 27 is aumatic		Sharon Bell/Sister	6408 4th Avenue, 7	Cakoma Par	k, MD 20912 Oc. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Disposition 20b. Pla cre 1 Burial 2 X Cremation 3 Removal from State Arcles	ace of Disposition (Name of cemetery, ematory or other place) nt Cremation Services 11		Hanover, Maryland
Itim iit. Pa irtmen ortant		4 Donation 5 Other Specify: 21. Signatury of Funeral Service I censee	22. Name and Address of Facility A	dent Crem	ation Services
Balti permit. Departm Importa injury o		KOKO	7522 Connelley Dri	ive, Ste.N	, Hanover, MD 21076
Physician		23a. Part I. Enter the diseas. , complications that caused the death. D failure. List only one cause on each line.			D = =4h
/Medical :aminer		Immediate Cause (Final disease a. Hypertensive a	theroscleortic cardio	vascular (disease
		or condition resulting in death) Due to (or as a consequence of):			
	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
uted nd ransit	Ĕ	d			
60, to be executed ysician and burial - transit	edical	X UNPENDED 23a,PII,	27, per ME, g897 11/23	3/09_TT	
Box 68760, a death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregna			23d. Date of delivery Month Day Year
30x 6876(death certificate te attending phy I for use as the b	iciar	past 12 months? 4 Pregnant at time of deat			
Bo e death the ath	Physician/M	1 Yes 2 No 9 Unknown g Unknown	which in the underlying cause diven in Part I	23e. Did toba	acco use contribute to the cause of death?
that th	by P	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Farti.		2 No 3 Probably 4 V Unknown
IS, F quires en sign ald be	ted	Obesity		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Corclaw replay be 2 shown	Completed			autopsy perform	ed? death?
Rec The ficate , page	ပ္ပ		26.Place of Death (Che		NO 1 V Tes 2 IN
ital	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	löu		esidence 6 🗸 Other: Scene
of V g Phys fler thi	<u>ء</u>	1 V Yes 2 No 28a, Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred
Sion of trending death. Attentions Attentions of the funity the funity at the funity a	fion	1 X Natural 5 Pending	1 Yes 2 No		
Division of Vital Records, P.O. Ind or Attending Physician: The law requires that the rather death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	me, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rural Route Number, City te)
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical Co		ie, death occurred at the time, date and place, ad/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date ar	(s) and manner as stated. Indicate the place, and due to the cause(s)
To To com	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item	O.C.M.E.		November 13, 2009
		Carol Allan, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21	1201	
	tate				
Regis		1101	fall		
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

		_ 1	For State Registrar			l / Depa		lealth ar	nd Mental Hyg		
	Physicia	n/	1. Decedent's Name (First, Middle, Last, Relda P.) Collins					2. Date of Dea Month Novembe	Day Yea	
-	Medic Examin		4a. Facility Name (if not institution, give s	treet and number)			4b. City, Town, o	r Location of D		4c. County of De	
			Patuxent River H	Health & F	ehab.		Laure			Prince C	eorge's
	Funeral Director		5. Social Security Number 6. Sec 1218-22-7942	x ☐ M 2 🖾 F	e (In yrs. las 82	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birtl (Month, Day March	h , Yea <i>r</i>) 29 1927 M	Birthplace (State or Foreign Country) Iaryland
ъ	ow	- 1	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	ection				10d. Inside City Limits
Marylan	28a-f sh atified a	recto	MD Prince G	George's		urel	Sation				1 ☐ Yes 2 💢 No
vith the	ms 23a or 28a-f show must be notified at	by Funeral Director	10e. Street and Number 6005 Brooklyn Br	idge Road			10f. Zip Code	0707		10g. Citizen of What USA	Country?
eath v	tems er mu	E I	11. Marital Status	12. Was Decedent 8		13. V			? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar	merican Indian,
036 s after d	ral", or iten Examiner r	ed by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates.	No	- 1	Yes, specify Cuba		ruerto Rican, etc.)	Black, Wi	nite, etc. White
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exa	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		+)	(Give I	lent's Usual Occup kind of work done O NOT use retired)	during most of	f working	16b. Kind of Busine	ss Industry
Martin Martin	ygiene her th t, the	S	12th	5+	<u> </u>	Reg	istered 1			Medi	cal
ind filed	even	To Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Middle,	,	
7	narke narke	-	Arthur T. Price	5:0					Mary Joi		
	alth and 27 is 1 ertraur		19a. Informant's Name/Relationship (Type Nancy E. James/Pe		pre.		,		or Rural Route Number ${ t aurel.}$ MD	r, City or Town, State,	Zip Gode)
Baltimore,	Department of He Important: If iten any injury or oth		20a. Method of Disposition 1		ce	metery, cren	sition (Name of natory or other plai ndel Crei		Date L/18/2009	20c. Location - City Odenton,	
alti. P.	ortme ortar injur	ł	21. Signature of Funeral Service License		Wes				Donaldson	•	
m Pa	an and and and and and and and and and a		Danico &	MOOK.	_M011	1 2			nue, Laure		0707
	ysician/ Medical		23a. Parr/1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	aMe	tasta	tic C	er the mode of dyir ancer of		rdiac or respiratory arr	rest,	Approximate Interval Between Onset and Death OVER 6 MONTHS
	aminer	<u>.</u>		Due to (or as a							
onted X	nd ransit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a							
30 So see the see of t			resulting in death) Last	Due to (or as a	a conseque	nce of):					
. Box 6876(has been signed by the attending physe 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	delivery Day Year
P.O.	ned by detar	ž	Part II. Other significant conditions co	ntributing to death b	ut not resu	lting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
	en sig ould be	ted k	Arteriosclero	tic Cardi	o Vas	cular	Disease		1 🗆 `	Yes 2 □ No 3 □	Probably 4X Unknown
ecor	te has be	omple					·		24a. Was a autop perfo 1 \square	osy prior t rmed? death	autopsy findings available to completion of cause of ? Yes 2 XNo
al F	rtifica tor, p	BeC	25. Was case referred to medical examiner?				26. P	lace of Death	(Check only one)	ZLINO IL	ies Z LANO
Vit	nis ce I direc	유	1 ☐ Yes 2X No	lospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatier	t 3 DOA Oth	er: 4 🗶 Nurs	ing Home 5 Resid	lence 6 Other (Sp	ecify)
on of Vital Re	atn. r: After this certificate ha e funeral director, page	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	28a. Date of inju (Month, Day		28b. Time of injury	wor	yat k? IYes 2 □ N		ow injury occurred	
Division of Vital Records,	within 24 hours after death To the Funeral Director: A completed filled in by the f		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulg	iry - At hon c. (Specify)	ne, farm, str	eet, factory, office		28f, Location (S City or Tow	itreet and Number or In, State)	Rural Route Number,
he Hospi	in 24 hou he Funer pleted fill	Medical		ner: On the basis of e	xamination	and/or invest	tigation, in my opini	on, death occu	ace, and due to the cau urred at the time, date a nd place, and due to the	nd place, and due to the	ne cause(s) and manner stated.
Jo the	within 2 To the I comple		29b. Signature and title of certifier	AR	0	11	29c. Licens			29d. Date signed (Mo	
			30. Name and address of person who co	ompleted cause of d	eath (Item :	23a) (Type. F		1721		Novembe	r 17, 2009
			Syed Sadiq 143	33 Laurel	Bowi	e Road		208,	Laurel, MI	20708	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re	0				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Joseph Culmone, Jr. 2009 2:20 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Ellicott City 8115 Yellow Pine Dr., Condo E If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) Dec . 12 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 X M 2 | F 1959Director 49 Yrs. 213-66-2979 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Howard Ellicott City 1 ☐ Yes 2 🔻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 USA 8115 Yellow Pine Dr., Condo E 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1XXNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Account Manager ABC Imaging 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosemarie Penta Joseph Culmone, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 Yellow Pine Dr., Condo E, Ellicott City, MD 21043 Rosemarie Culmone/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Ngy09²⁵ 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State West Arundel Crem. Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 23a. Feft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Myocardia Priysician disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of): Exami certificate be executed and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Jeter death.

**I Director: After the 'in by the fire 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by within 24 hours after To the Funeral Direc determined Hospital Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifie

Nicholas B.

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Argento

MD,

14201

Signatur

Laurel

134018

Park Dr., Suite 214, Laurel, MD 20707

November 20, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death **Physician** 2:20 PM Rarbara Carter NOVEMBER 16, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES MEDICAL CENTER LAPLATA CIVISTA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | May 25, 9. Birthplace (State or Foreign PA 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1942 1 □ M 2 □ XF 172-34-6973 67 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a, State r than "natural", or items 23a or 28a-f show 1 Yes 2 No Waldorf MD Director Charles 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 901 Fowler Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, In Mangine. Elementary/Secondary (0-12) College (1-4or 5+) Underwriter Mortgage Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Bulinsky Anna Waksmunski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rick Carter 901 Fowler Court Waldorf, MD 20602 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sts. Peter & Paul Cem 11/20/09 Portage, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mark A. Serenko Funeral Home 21. Signatury of Funeral Service Licenses 812 Main Street Portage, Pennsylvania 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory shock or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate ause (Final isease of condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (or as a consequence of) burial-tran Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 🗆 Yes Be Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 To the Hospital or Attending Physician: within 24 hours -fter death.

To the Funeral Director - After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes⁄ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturai 1 □Yes 2 □No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifie 1 Certifying Physician: To the best of my knowledge, deaty occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or prestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sign ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 and address of person who completed cause of death (Item 23a) (Type, Print) 200 024 CHOL CH ON 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ARTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20astate 32 Maryland / 6897 artine 20 19 earth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 11:34 AMM November 17, Leslie Lee Cronise Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Halethorpe 23 Birdknoll Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 5, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 214-40-6907 67 Director 1942 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Evanings must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ត់ 23 Birdknoll Court 21227 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 166-68 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🏋 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It a many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Lee Cronise Sr Katherine Schaub 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Cronise/daughter 1310 Meadowvale Road Glen Burnie, MD Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 remation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) 111 3 Cate 11/23/2009 Bayview Crematory Baltimore, MD Name and Address of Facility Hubbard Funeral Home Street 21. Signature of Funeral Service Lic RODATO 4107 Wilkens Ave. Baltimore, MD Part 1. Inter the diseas, or com, that it is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscleratic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records.

Division of Vital

31. Date filed (Month, Day, Year)

Militella

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6 Trimble Hill

Registrar

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C899 1/08/10 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marie Correia 11/14/2009 10:15pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Min (Month, Day, Year) 08/26/1919 1 □ M 2 1 F 90 Yrs. MA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Anne Arundel Crofton 1 ☐ Yes 🏖 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: 2 **¾**Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Joseph Ferry Flora Silva ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1032 Mt. Airy Road, Davidsonville MD 21035 Flora Izzo / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 11/18/2009 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Victor P. Doda, Jr^{22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230} Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last nsequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate has 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 29b. Signature and title of pertifi

30. Name and address

DHMH 17 Rev 1/2001

f person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

am Highway Sw

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19, 2009 **Physician** Harriet Blanche Chard 6:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Woods Nursing Center Baltimore Rossville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 09/29/1931 **Funeral** Hours Months Days 1 □ M Director 214-30-5169 78 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Middel River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3808 New Section Road 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 8 Inventory Control Printing other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fi Jealth and Mental H Be is marked o Lancelot Chard 2 Elizabeth Kaltenhauser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau Robert T. Chard, Sr. (Brother) 6528 Bella Vista Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐Removal from State Gardens of Faith 11/21/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Sonice Elcensee 22. Name and Address of Facility Runeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia. Cause (Final disease) or condition respiratory arrest, single of condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single of cause (Final disease) or condition respiratory arrest, single or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Final disease) or cause (Fin 1407 Old Eastern Avenue, Essex, Maryland 21221 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-trar P.O. Box 68760 ERTENSION attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 2 200 9☐Unknown 9 Unknown signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed PUTHYRUIDISM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy MUNARY HYPERTENSIUN perfor 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes Other: 2 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 | Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 40008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Franklin Square TERRE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37210 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/17/2009 **Physician** 10:10 P M Gertrude M. Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Frederick Villa Nursing If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/3/1925 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 X F Months Days Hours 216-20-9207 Director 84 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important; if Item 223a or 28a-f show important; if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandrat must be notified at once. 1 ☐ Yes 2 TX No Director Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 290 Bloomsbury Avenue Apt. 40 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 XXNo Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Gallup ပ Harry L. Grove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21227 Terry Hansen (Friend/Pers. Rep) 1015 Francis Avenue, Arbutus, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Poplar Springs Ceme. 11/21/2009 Lisbon, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHEROSCIEROTIL CV DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 Hospital: Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

Medical

Ternond

29b. Signature and title of certifier

and manner stated.

29c. License number D50303 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robolto prnendo

Rd SHE 205 Colonsullo MO 21228 SIGN Rollin

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08861 2009 37211 State of Maryland / Department of Health and Mental Hygiene Glenda Kay Clements 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day November 15, 2009 0650 hrs **Medical Examiner** Clements Glenda Kaye 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 400 North Mulberry Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Min. Country) MS Director Aug 27, 1955 587-98-3789 54 1 M 2 X F Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 XYes 2 No 28a-f shov must be notified at once. Washington Hagerstown after death with the Maryland Directo 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 907 Hamilton Blvd. 21740 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No Specify: White f Yes. Give Year Yes 2 X No specify: Widowed 4 X Divorced 3 marked other than "natural", c event, the Medical Examiner "natural" þ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filted within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturi injury or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Agent Insurance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Genevieve Fortner Be John Wesley Clements 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (sister) 150 Trails End, Flora, MS 39071 Mellany Kitchens 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place)
Salem Baptist Church 1 X Burial 2 Cremation Removal from State 11-21-09 Learned, MS Donation 5 Other Specify Cemeter 22. Name and Address of Facility Glenwood Funeral Home, 21. Signature of Funeral Service Licenses Nonan 145 Hwy 80, Vicksburg, MS Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Medical a Multiple injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 4. Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
2. Financial Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, X UNPENDED per ME G898 12/10/09 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Day 3b. Was decedent pregnant in the Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes No 28d. Describe how injury occurred passenger in auto/fixed 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 Yes 2X No Natural Pending Fd 11/15/09 Fd 6:41 object collision am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 400 N. Mulberry Street, MD 3 Could not be Suicide road determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 15, 2009 O.C.M.E.

State Registrar 30. Name and address of perso

Jack Titus MD.

31. Date filed (Month, Day)

Registrar's Signal re

w o completed cause of death (Item 23a)

Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# ToperFH, G897, 117, 24, 109, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CC AM Ernest Ray Chalk 13 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL Rosedale Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. Hours 1 X M 2 □ F 219-22-2778 82 Jan31,1927 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Miclical Examiner is ust be notified at 1 □Yes 2 □No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 730 Corby Road 21221 USA 23a Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Yes Give 9 Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Brakeman Railroad 10th marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Robert E. Chalk Viola P. Kupka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S of Health a Donald Chalk /son 730 Corby Road Baltimore MD 21221 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Cemetery 11/21/09 Baltimore MD o Important: If it any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. In faction Immediate Cause (Final non-ST-SeamenT Elevation myocardia
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Colitis DIFFICILE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. physician Physician/Medical use as attending IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy for 1 Month Year 5 Other (specify) 0 ☐Yes 2☐No the detached 9 Unknown signed by t ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No death. Director: in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier A PATEL RESODOO 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Balto md 4000 FRANKLIN SQUETE 21237 DR AMEE PaTel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar park

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Bret William Carlson November 17, 2009 12:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 402 Tidewater Dr. Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ₩ 2 □ F 341-64-7187 Director Aug. 15, 1963 Illinois 46 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~ any highly or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland | Harford Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 402 Tidewater Drive 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soldier U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Lenore Schroeder Carl Evert Carlson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Tidewater Dr., Havre de Grace, MD 21078 Amy E. Carlson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat'l Cem. 1-6-2010 Arlington, Virginia 4 Donation 5 Other (Specify) 21. Si xi McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic lung cancer 19 mouth /Medical Due to (or as a consequence of) Examiner tobacco use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) □Yes ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 1 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death.

Director: A in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0063610 11/18/2009 MD 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) Belcap MD 21017 Honard Jany 103 A BWa 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar NOV 20

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 645 November Katherine Amelia Compton 16 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner asto Birthplace (State or Foreign Country) If Under If Under 1 Year 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Oct. 04 1918 Months Days Hours Min. 1 🗆 M 2 🔀 F 91 MD 213-34-6536 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c, City, Town or Location 10a. State 10b. County at with the Maryland Director ral", or items 23a or 28a-f sl Examiner must be notified 1 🗌 Yes 2 🔀 No Caroline Denton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21629 USA 1311 Chesapeake Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should 'e filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates Specify 3 X Widowed 4 Divorced Completed per it. Page 1 and 2 should le filed within 72 hour. De artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatir event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 2 Marie Hetche Chambers Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1186 Mahoghany Lane West, Crownsville, MD 21032 Pat Clawson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 20 Nov. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2009 Cedar Hill Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature f Funeral 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 3 in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No after death.

I Director: After this certificate has been signed by the and in by the function that the function and the function page 2 should be detached. Unknown 9 Unknown death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes 1000 Yes 26. Place of Death (Check only one) 25. Was case referred to Be examiner? Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred <u>ن</u> (Month, Day, iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Certifical Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed filled in by the funeral within 24 hours a

> State Registrar

Medical

Homicide

3

29b. Signature and title of cert

31. Date filed (Month, Day, Year)

29a Certifier

(Check only one determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rec

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

65656

29d. Date signed (Month, Day, Year)

2009

MD 2160

		•	1 - State of Ma State Registrar	aryland / Depa <i>Cei</i>	artment of Heal rtificate of Dea				
	Physicia	an	1. Decedent's Name (First, Middle, Last) Beth Currie				2. Date of Death Month	Day Year	3. Time of Death 450 A M
and it	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		NoV	17 2009 4c. County of Deatl	
ز	Examin	er	ST. AGNES HOSPI	TAL	BALTI			N/A	
	Funeral Director		215-28-2033 1 ¹ M 2 F	e (In yrs. last birthday) 78 Yrs.		Jnder 24 Hrs. purs Min.	8. Date of Birth (Month, Pay, Dec 21,	Year) 9. Birtl	hplace (State or Foreign untry) LIT1015
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Baltimore	C	atonsville				1 □Yes 2⁄√□No
	or 28	Director	10e. Street and Number		10f. Zip Code	00	10	g. Citizen of What Co	untry?
	eath w	Funeral	715 Maiden Choice Lane, Ap	Ever in LLS 13	2122 Was Decedent of Hispan		cify Yes or No-	USA 14. Race - Ame	rican Indian,
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Marical Evanian numbor notifica a	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent to Armed Forces? 1 Never Married 2 Married 15. Was Decedent to Armed Forces? 1 Never Married 2 Married 16. Was Decedent to Armed Forces? 1 Never Married 2 Married 17. Was Decedent to Armed Forces? 1 Never Married 2 Married 18. Was Decedent to Armed Forces?	No l	Was Decedent of Hispan If Yes, specify Cuban, Me 1 □Yes 2 XNo <i>Sp</i>	exican, Puerto R pecify:	lican, etc.)	Black, White	
2-0	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during	g most of working		6b. Kind of Business/	Industry
121	within jiene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5	i+)	DO NOT use retired) acher		F	ublic Scho	ool System
pd 2	al Hyg other	BeC	17. Father's Name (First, Middle, Last)			Mother's Name		laiden Surname)	
ylar		10 E	William Kopelke				nce Pott		
Mar	12 s h ar 7 ls trau		19a. Informant's Name/Relationship (Type. Print)		ng Address <i>(Street and P</i> W. 34th Stre				
re, l	1 and Heal em 2		Paul Kopelke, Nephew 20a. Method of Disposition		osition (Name of matory or other place)			20c. Location - City or	
altimore, Maryland 21215-0036	Page nent o	-	1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Cr	ematory Inc	. 11/18		Baltimore	,
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Thomas	Gregor C	2. Name and Address of remation So 99 Frederic	ciety O k Road	t Maryla Baltimor	e, Marylar	nd 21228
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not en					Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition resulting in death)	reumonia					2 WE-CKS
1	/Medical Examiner		Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	a consequence of):					
	ecutec and transii	Examiner	triat initiated events c.						
68760,	icate be executed physician and the burial-transit	a E	Due to (or as	a consequence of):					
687	ificate g phys	edical	d				-		
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burlat-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	quires that n signed b ald be deta	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause given in	Part I.		acco use contribute to	
of Vital Records,	The law requir cate has been s page 2 should	Completed					24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of
ital	sician: The certificate rector, pag	Be Co	25. Was case referred to medical examiner?		26.	. Place of Death			2 LINU
of V	Physic this ceral direct	မ	1 Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatie				nce 6 Other (Spe	ecify)
	ding After fune	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Inju (Month,	ury 28b. Time (lnjury	Work?	2 🗆 No	28d. Describe ho	w injury occurred	
Division	I or Attendater deatl	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, farm, st c. (Specify)			28f. Location (St. City or Town	reet and Number or R ı, State)	ural Route Number,
PIJ	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physician. To the best (Check only one) 2 Medical Examiner: On the basis of and manner st	of examination and/or i	th occurred at the time, onvestigation, in my opinion	date and place, a on, death occurre	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier A Whatter	M.D.	29c. License nu	240 (9d. Date signed (Mon	th, Day, Year) 7, 2009
			30. Name and address of person who completed cause of a goo Caton Aver		BALTIM	TORE,	MD	21229	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 0 20	rar's Signature	A Company				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:15 AM November 2, 2009 Dooley Therase /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Yrs. 578-28-6142 9/4/1926 83 Washington, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be notified at 1 ☐Yes 2 No Director Avenue MD St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 37832 Paul Ellis Road 20636 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 8 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Webster Mary Μ. Keenan Frank R. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judy Schroeder/Daughter Tip Hill Drive, La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anataw Gifts Registry 11/10/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Aneral Servi & License 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANDO RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERCAPSIZ Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner COP i physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as t by the attending I ached for use as IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 □ Yes 2 🖳 📆 🛈 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the ^{29c. License}**D69**683 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

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WIZ MANNI

30. Name an Jackress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

St Mary's Hospital

Leonardtown MD.

			For State Registrar	State of Mai	ryland / D (epartment of Certificate of	Health and I <i>Death</i>	Mental Hyg ا	giene 2009	37217	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death	
	Medic	al		DACHILLE				NOV.	Pay Year		
-	Examin	er	4a. Facility Name (if not institution, give : 4518 Ambermill				or Location of Death	1	4c. County of Death Baltimore		
	Funeral Director		214-10-3/30	X 7. Age (i	In yrs. last birtho 88 Yı	Months Days		8. Date of Birt (Month, Day October	^h ^{9. Bi} Co 5 , 1921 Ma	rthplace (State or Foreign ountry) ryland	
-	show	'n	Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, Town o	or Location				10d. Inside City Limits	
	Maryla 18a-fs tiffied	Funeral Director	Maryland Baltimo	re	Pe	rry Hall				1 🗆 Yes 2 🟋No	
:	a or 2 be no	ΙĒ	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?	
3	ns 23	ner	4518 Ambermill Roa				1236		USA		
0036	permit. Page 1 and 2 should be filed within /2 hours after death with the Maryland Department of Health and Mential Hygiene. Unportant if firem Z7 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates.		13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Decity Yes or No- Dican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.	
21215-0036	hin 72 hor ne. than "nat ie Medica	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Seconday (0-12)		(G	eccedent's Usual Occu Give kind of work done fe. DO NOT use retired	during most of wor)	king	16b. Kind of Business Blue Cross &	Blue Shield	
ς Ο	Hygie Hygie other ent, th	l as l	12 years 17. Father's Name (First, Middle, Last)		-	Claims Adj		ne (First Middle	Insura Maiden Surname)	i Ce	
lan'	fental fental rked ric eve	욘	Charles E. Davis					E. Geier	,		
lary	should and N is ma auma		19a. Informant's Name/Relationship (Type	pe, Print)	19b. f	Mailing Address (Street	and Number or Ru	ral Route Number	; City or Town, State, Z	ip Code)	
≥ ∘	and 2: lealth sm 27 her tr		Sandra D. Morgan 20a, Method of Disposition	Daughter					all, Maryla		
altimore, Maryland	t. Page 1 at the the the the the the the the the th		1 Burial 2 XCremation 3 4 Donation 5 Other (Specify)	cemetery,	Disposition (Name of crematory or other plate Crematory	20	mber , 2009	20c. Location - City o	Maryland	
Ba	permir Depar Impoi any in once.		21. Signature of Funeral Service License	onnel	les				Dundalk,P.A Dundalk,MD.	21222	
			23a. Part 1. Enter the disease, or comp shock, or heart failure List only on	lications that caused the cause on each line.	ne death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
P	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. aspiration						Onset and Death	
	Examiner		ſ	Due to (or as a c	consequence of)					Zyeis	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence of)					5/0.3	
y 1	and transit	Examiner	Cause (Disease or linjury that initiated events	C. Due to for on a	22222222222						
	physician and the burial-transit	edical E	resulting in death) Last	Due to (or as a c	onsequence of	•					
3760	g phys	/ledi		a							
. Box 68	To the rospital of Attending Frigstran, the law requires that the beam bettinbate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 Ectopic pregnar 5 Other (specify)	псу		23d. Date of de Month	elivery Day Year	
P.O	ned by	by PI	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying cause g	iven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?	
ds,	en sig	ted !						1 🗆 1	∕es 2 □ No 3 □ F	Probably 4 ဳ Unknown	
Recor	ne has be vage 2 sho	Completed						24a. Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of	
tal	ertifica ctor, p		25. Was case referred to medical examiner?				Place of Death (Chec		Z (BHO)		
fVi	this o	유	1 ☐ Yes 2 🔣 No 27, Manner of Death	lospital: 1 Inpatien 28a. Date of injury	t 2 ER/Outp	atient 3 L DOA			ence 6 Other (Spe	cify)	
o uc	th. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,)		iry wor	ryat k?]Yes 2. ☐No	28d. Describe h	ow injury occurred		
Division of Vital Records, P.O.	of Actional Arrivations, the rail of the control of	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (, street, factory, office		28f. Location (S City or Town	treet and Number or Run, State)	ural Route Number,	
	oue rospital of within 24 hours afti To the Funeral Dir completed filled in	Medical	(Check 2 Medical Examir	ner: On the basis of exam	mination and/or i	nvestigation, in my opin	ion, death occurred a	at the time, date ar	use(s) and manner as st nd place, and due to the	cause(s) and manner stated.	
V F	withi To th		29b. Signature and title of certifier	804.40		29c. Licens	00 20 604		29d. Date signed (Mont	th, Day, Year)	
			30. Name and address of person who co	ompleted cause of dea			. 1. 6 . 4	21022			
	Sta	e	31. Date filed (Month, Day, Year)	Richard A. Sers. 32 Registrar's	Signature	W 10122 HIVE	, Literville, but	21043			
	Registra		MAY 2 0 200	9 Seleva	Signature	Jako					

State Registrar MD

alck

JON

Cuton Avenue

32. Registra Signature

09-08935 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 Sabin Dean State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ November 17, 2009 1555 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/Y) 9. Birthplace (State o 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Foreign Country) Months Days Hours Min 36 Director 217-90-2010 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County Oc. City, Town or Location 3nv 1 Yes 2 No 28a-f show more hours after death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country ユルル 2027 Funeral 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes 2 X No ac If Yes, Give Year Yes 2 No specify: 4 Divorced "natural" 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Bus 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Baltimore, MD 21215-0036 2 /2 ourse 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ho ngmire Informant's Name/Relationship (pe, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code If item 27 is heirle 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Department o 11-25-2009 Other Specify: Donation 5 ne and Address of Fac nature of Funer Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Complications of chronic alcoholism Immediate Cause (Final disease xaminei or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): The law requires that the death certificate be executed events resulting in death) Last the attending physician and ed for use as the burial - tran Physician/Medical X UNPENDED AMENDED 23a,27,perME, g898 12/21/09 TT 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed peen : 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? 1 V Yes 2 No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one Be examiner?

Division of Vital Records, P.O. Box 68760,

this certificate has Hospital or Attending Physician: 24 hours after death. After To the Funeral Director:

the

1 V Yes

27. Manner of Death

Accident

Suicide Homicide

29b. Signature and title of certifier

Ana Rubio MD. 31. Date filed (Month, Day, Year,

5

Pending

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a)

OCME

2009

1 X Natural

29a. Certifier (Check only

Certification:

Medical

State

Registrar

3

DHMH 17 Rev 1/200

Other

28f. Location (Street and Number or Rural Route Number, City

November 18, 2009

29d. Date signed (Month, Day, Year)

Residence 6

28d. Describe how injury occurred

2 V ER/Outpatient

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

Inpatient

28a. Date of Injury (Month, Day,Year

and manner stated

Assistant Medical Examiner

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

28c. Injury at Work?

29c. License number O.C.M.E.

Yes 2 No

Nursing Home 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 37220 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 13:42 PM Charles James Dwyer NOV 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Union Memorial Hospital n/a Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec. 21, 1 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 1 X M 2 - F Months Days Hours Min. 110-24-5229 80 New York 1928 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits New Jersey Monmouth 1 Yes 2 X No Matawan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 Inglwood Lane 07747 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes : 2 No If Yes, Give Korea Year or Dates. 1950–1952 1 Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Trial Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Nora Palmer William Dwyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Glen Dwyer (Son) 60 Fordham Drive Aberdeen, New Jersey 07747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Entombment 11/25/2009 Gabriel Cem. Marlboro, New Jersey 21. Signature of Fun S 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. UNKIN complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. Part 1. Enter the disease, of shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final Severe disease or condition Wee resulting in death) Due to (or as a consequence in: Preumonini and winde MACI CONCINCINO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Oranau Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Medical Examiner sician and burial-transit that the death certificate be executed attending physician for use as the buria ed by the signed t s certificate has b lirector, page 2 sl this

Physician/

Medical

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

b

Completed

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Certificate:

Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

other traumatic event, the Medical

permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Physician/

death

within 72 hours after

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral Hospital

1 Li Yes 2 VX No	1 X Inpatient 2 ☐ ER/Outpatient 3	DOA 4 Nursing H	Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury M	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Examine	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier	- MD	29c. License number AT 243894G	29d. Date signed (Month, Day, Year) 3 - BH 11/19/09 JH; 10							

State Registrar

201 EasthPwy lousser HOKAYEM 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Union Memorial Hospital, Baltimore, MD 21218 32. Regetrar's Signature

			1 - For State Registrar	Otato or me	Ce		of Death		Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Las.)		_		2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic		Norma Elizabet	h Dean				Novembe		009	1:55 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of D	Death	4c. County of		
			Brightview Assist			Bel			Hari		
	Funeral		5. Social Security Number 6. Se	× ⊐M 2¥∑F 7. Age	e (In yrs. last birthday		Year If Under 24 Days Hours M	Min. (Month, Da)	h v, Year)	9. Birthp	
	Director		214-07-7966 Usual Residence of Decedent		92 Yrs.			May 3,	1917		Delaware
	and		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Mary f sh	Ö	 Maryland Harfor	a	Bel Air						1 □ Yes 2 📉 No
	the l	Directo	10e. Street and Number	u	Der Ari	10f. Zip Ce	ode		10g. Citizen of W	hat Cour	ntrv?
	with 3a or		519 Idlewild Roa	đ		210			USA		•
	ns 2	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S. 13			? (Specify Yes or No- uerto Rican, etc.)		- Americ	can Indian,
٥	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I marked other than "natural", or Items 23a or 28a-f show in maric event, I'm Mcdigal Evai, i'm right be rightlind at	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 🛣	lo			uerto Rican, etc.)	Black	, White,	etc.
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ה ה	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	edent's Usual (Occupation done during most of	i working	16b. Kind of Bus	siness/In	dustry
21215-0036	thin 7.	nple	Elementary/Secondary (0-12)	College (1-4or 5	lifa	DO NOT use	etired)	working			
	ed wi	Ço	12		Ho	memaker			Own Ho	me	
ב	be file tal H d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Surname)	
<u> Za</u>	should be filed withir nd Mental Hygiene. marked other than Imatic event, Inc.	ဥ	Foster Bernard Po	owell			Sadie	- Lavenia	Matthews	3	
Maryland	2 short and ls m		19a. Informant's Name/Relationship (7)		1			or Rural Route Numbe			
~` ~	and lealth m 27 her ti		Donald P. Dean /	Son				Bel Air,			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Disp cemetery, cri	osition (Name ematory or othe	of or place)	Date	20c. Location - 0	Dity or To	wn, State
Ē	men tant: jury		4 Donation 5 Other (Specify				Gdns. 11	L/16/09	Cambrido	e, N	Maryland
ā	epartition pour la la la la la la la la la la la la la		21. Signature of Funeral Service Licens	ee /		22. Name and	Address of Facility	McComas F			
	70 E # 9		steples U	Auch	5	0 W. Br	oadway, E	Bel Air, M	aryland	2101	4
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lir	the death. Do not e	nter the mode o	of dying, such as car	rdiac or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ade	It fach	~ to-	thrive				Onset and Death
نبو	/Medical		resulting in death)	Due to (or as	it fulli a consequence of): tic intr	1 .					<u> </u>
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A 1	₽	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence of).					1,	0.10
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õ	ertific ling p	Mec	IF FEMALE:							- !	
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5	the a	/sic	1 □ Yes 🏂 No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (spec	ify)		Mo		buy 10th
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ecords,	sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	by	harmone significant conditions co		break w		se given in Fait i.		es 2 □ No		pably 4 🗆 Unknown
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2	law las b	Completed			-			— 24a. Was a	sy p	rior to co	psy findings available impletion of cause of
	The sate h	် ပ						perför 1 □Yes	med? d 2.5 No 1	eath? □Yes	2 No
N I G	nding Physician: th. : After this certifica s funeral director, p	Be	25. Was case referred to medical examiner?					Death (Check only or			
5	hysl this c	٩	1 Yes 2 No	fospital: 1 ☐ Inpatie	nt 2 ER/Outpation	ent 3 DOA	Other:	ng Home 5 Resid	lence 6XXX)the	r (Speci	assisted Living
	ng P	ü	27. Manner of Death 1	28a. Date of Injui (Month, Day		of 28c	Injury at Work?	28d. Describe h	ow injury occurre	ed	<u> </u>
DIVISION	al or Attending F s after death. Il Director: After ed in by the funere	ertification:	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No				
Ĕ	r Ati ter d irect n by	ŧ۱	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, s . <i>(Specify)</i>	treet, factory, o	fice	28f. Location (S City or Tow	Street and Numbern, State)	er or Run	al Route Number,
ב	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	O									
	Hosp 4 hou Fune ely fi	ca	(Check only 2 ☐ Medical Exam	sician: To the best of iner: On the basis of	of my knowledge, dea examination and/or	th occurred at nvestigation, in	the time, date and p my opinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as :	stated. o the cause(s)
	the hin 2, the find 2, the find find 1, the find 1, th	Medical	one)	and manner sta	ted.						
	7 ₩ 1 0 0 0	-	29b. Signature and title of certifier	0		-	icense number		29d. Date signed	(Month, \9	Day, Year)
		Ì	1 lug	7		ע	<i>L</i> (<i>L U</i> ,		1700	- (
			30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type	Print)	7 .7 1	bel Air 1	no zes	14	
			PATRICIA DUSY		512 M.	I'V PN	and the	- CIN	11 =	7	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's gnature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37222 State of Maryland / Department of Health and Mental Hygiene 19 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary Joseph Dickey 15, 2009 2:28 p M November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill 1811 Ridgecroft Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□ M 2√ Months 216-28-3802 78 Yrs Director 6, 1931 Mary Land Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "M-dical Expresses must be rollified at 1 □Yes 2XNo Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 Ridgecroft Drive 21050 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify 3 XWidowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Aloisius Johnson Violet Josephine Scanlin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 is item 27 other t Karen Dennis / Daughter 1716 Ingleside Road, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) i of F 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/1/09 Arlington, Virginia 4 Donation 5 Other (Specify) Arlington Nat'l Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter tricenying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi be execu Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.O. 1 ☐Yes 2 ☐ No the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy certificate Division of Vital 1 □ Yes 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) PHTSICIAN 00058475 NOVEMBES R 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENATPURE 602 BRLARRMD 0.0 ROAD 32. Registrar's Sonature 31. Date filed (Month, Day, Year, State 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 16, 2009 Eva Eloise Dougherty 4:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac Valley Nursing and Wellness Center Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Colorado **Funeral** 8. Date of Birth (Month, Day, 1 □ M 2 🕅 Months Days Hours Director 521-24-1189 87 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20130 Rothbury Lane #5404 20866 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? δ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates X Yes 2 □ No Specify: Spanish 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Security Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph L. Lobato Pauline Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Schrager/Daughter 18912 Blue Heron Lane, Gaithersburg, MD 20879 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State November 4 Donation 5 Other (Specify) 2009 Montgomery Crematorium, Inc. 19, Bethesda, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Signature of Funeral Service Licen alon M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Four Years Physician disease or condition resulting in death) Advanced Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Ectopic pregnancy Month Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? Yes 2 🔯 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\overline{\chi} \) No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Hospital within 24 hours a To the Funeral C

Anurita Mendhiratta, M.D.

State
Registrar

Anurita Mendhiratta, M.D.

31. Date filed (Month, Day, Year)

NOV 2 0 2009

re and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2401 Research Blvd.

29c. License number

D38262

29d, Date signed (Month, Day, Year)

November 17,

#330, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16b & 20a, per FH 9897 11/20/09 TT & 22
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $\overset{\mathsf{Day}}{12}$, Month William J. Davis November 2009 12:54 PMM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr 27, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Director 1925 081-32-2054 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar" or items 23a or 28a-f show amy injury or other traumatic event, I'm Madical Evantical must be partitled. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? 700 Braeburn Drive Funeral 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify: White δ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry General Electric Corp. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 engineer U.S. Navy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Davis Dorothy Conover ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 M Street NW Washington, DC 20037 19a. Informant's Name/Relationship (Type. Print) Anna Popov/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Notice (Specify) in State Chesapeake Crem. 11.20.09 Beltsville, MD 21. Signature of Funeral Service Licensee Ronald So Wade, Director Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine executed burial-trans and Due to (or as a consequence of): P.O. Box 68760 attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ō 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has 24a. Was an page 2 autopsy certificate Ce Zya 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mannef of Death 28b. Time of 28c. 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D/3 339 16/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Tsunie Chanchien 11424 Livingston Rd. Ft. Washington, MD 20744

09-08939 Shawntrice English	• •	n Black Indelible Ink. Ensur and / Department of Health an		
	1- For State	Certificate of Death		2009 372
Physician/	1. Decedent's Name (First, Middle,Last)	1 (Reg. 2. Date of Death Month	3. Time of Death
Medical Examiner	Shawntrice Er	iglish	November 1	
i j	4a. Facility Name (if not institution, give street and not maryland General Hospital	umbér) 4b. City, Town, or Baltimore	r Location of Death	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year Months Day	vs Hours Min	Foreign
	15-86-4242 1 M 2 5 Usual Residence of Decedent	38 Yrs.	Nov 14	, 1971 Country) Mary and
and f show any once.	10a. State N A	10c. City, Town or Location Baltimal	,	10d. Inside City Limits 1 Ves 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number	40+ 703 10f. Zip Code) 1217	Citizen of What Country?
er death with t , or items 23a r must be not Funeral	11. Marital Status 12. Was De 1 Never Married 2 Married Armed F		ispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
	Widowed 4 Divorced If Yes, Give Ye or Dates:	2 No	o specify:	specify: Black
nours a	15. Decedent's Education (Specify only highest gra	during most of working life		6b. Kind of Business/Industry
nore, MD 21215-0036 may be and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygene. tt. If item 27 is marked other than "matural", or items 23a or 28a-1 sho other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	12	Nurse		Medical
Baltimore, MD 21215-00 cernit. Pages I and 2 should be filed wir Department of Health and Mental Hygien important: If item 27 is marked other injury or other traumatic event, the March of Be Top Be Com	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, Mai	den Surname)
212 rould b id Menid is mark tic ever	19a. Informant's Name/Relationship (Type, Print)		eet and Number or Rural Route Numbe	r, City or Town, State, Zip Code)
MD id 2 shallth and in 27 is		other 2210 Call	ow Ave. Bal	timore, MD
Baltimore, MI semit. Pages I and 2 s opertment of Health a important: If iten 27 njury or other traum	20a. Method of Disposition 1 Durial 2 Cremation 3 Removal f	20b. Place of Disposition (Name of concept community of concept community of concept community of concept community of concept	emetery, Date 2	Oc. Location - City or Town, State
5 ~ 8 5 5	4 Donation 5 Other Specify: 21. Signature of Funeral Service Livensee	Mt. Zion	11 28 69	Baltimre, MD
Balti permit. Departn Import injury c	Min 9 Am	Leel 4 Hoto Like	perty regular	Ave, Galto MD 21207
Physician /Medical	23a. Part I. Enter the disease, or complications that failure. List only one cause on each line.	aused the death. Do not enter the mode of dying	g, such as cardiac or respiratory arrest,	Between Onset and
xaminer		noid hemorrhage a consequence of):		Death
	- Due to (or as	perry aneurysm, anterior communicat	ting artery	
iner		a consequence of):		
ed nsit	(Disease or injury that initiated C.	a consequence of):		
	d			
o, be ex sician ourial -	UNPENDED AMENDED			
876 tifficate ng phy as the t	23b. Was decedent pregnant in the	outcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day Year
D. Box 68760, It the death certificate be executly by the attending physician annached for use as the burfal - trapply sician/Medical	1 Voc 2 No 0 at Unknown	nant at time of death 5 Other (Specify)		
D. Bc the de by the s by the s Phys	Part II. Other significant conditions contributing		given in Part I. 23e. Did toba	cco use contribute to the cause of death?
ires that the signed by 1 be detach		,		2 No 3 Probably 4 V Unknown
cords, taw requir thas been s e 2 should t			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Records, The law requires fricate has been sig			performe	ed? death?
ician: 1 icertific rector, p	25. Was case referred to medical	26.Plac	ce of Death (Check only one)	
of Vital Recing Physician: The After this certificate uneral director, page on: To Be Con	examiner? 1 ✓ Yes 2 No Hospital: 1	Inpatient 2 PER/Outpatient 3 DOA		esidence 6 Other:
n of ding Ph. h.: After the funeral	27. Manner of Death 1 Natural 5 Pending 28a. Date (Mont	h, Day,Year)	iury at Work? 28d. Describe how	v injury occurred
Division of Vital Records, ral or Attending Physician: The law requir rs after cleath. al Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed ertification: To Be Completed	2 Accident Investigation 28e Pla	ce of Injury - At home, farm, street, factory, office		eet and Number or Rural Route Number, City
Division or spital or Attending nours after death neral Director: After filled in by the fume Certification:	3 Suicide 6 Could not be determined (Specify		or Town, Stat	
	29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, death occurred at the time, of examination and/or investigation, in my opinio		
To the He within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis and manner 29b. Signature and title of certifier	stated.	· · · · · · · · · · · · · · · · · · ·	29d. Date signed (Month, Day, Year)

State

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

Registrar

O.C.M.E.

November 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** NOVEMBER 16 2009 12:10 P M marles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL OF BALTIMORE DALTIMORE CITU 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 7-34-2833 Director ary Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination until be mailthed at 1 ☐ Yes 2 ☑ No Director ud 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.J.A 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> Specify Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Pages 1 and 2 should Informant's Name/Relationship (Type. Print) doughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Name and Address of Family ou 21. Signature of Funeral Service Licensee Naugan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUNTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ PENAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 🕱 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00690Z1 NOVEMBER 16, 2009 wer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trick M.D. SINAI HOSPITAL OF STIN JU 31. Date filed (Month, Day, Year) NOV 1 9 2009 32. Registrar's Signatur State Registrar

WOW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 Nov. 15, Fish Sr. A^{M} Roland Leonard 11:24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7-9-1930 9. Birthplace (State or Foreign **Funeral** 218-28-7534 1 M 2□ F Baltimore **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at Director 1 □Yes 2 No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 5145 Bartholow Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: white Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Represenative Balto. Gas and Elec. other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Fish Sr. Christine Wegworth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia M. Fish-wife 5145 Bartholow Road, Sykesville MD 21784 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 20c. Location - City or Town, State 20b. Place of Disposition (Name of centerery, crematory or other place) 20a. Method of Disposition 1 Neurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Loudon Park Cemetery 11-18-2009 Baltimore MD Signature of Forecal Service License 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOCARDIAL INFARETION IDAY UTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: If or Attending Physician: The law requires that the death certificate be executed after death.
I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by OSTEOARTHRITIS OF THE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? RIGHT 24a. Was an autopsy 10/20/2009 perform 2 No 2 No 1 ☐ Yes 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 Yes 2 No

27. Manner of Death
1 Natural 5 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

X

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JA

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SOON

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1 hm

2. Registrar's Signature

MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5808 MAIN STREET, ELKRIDGE

D 22832

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month V. **Physician** 000 Grace Elizabeth Farrington /Medical 4c. County of Death Facility Name (If not institution, give street and number, Town, or Location of Death Examiner forz bilitationCente If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Vear) Months Days Hours 1 □ M 2 🔀 F Director 214-24-4914 87 1922 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☑ No traumatic event, the Modical Examinar must be notified Director Maryland Harford Edgewood death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 23a 300 Palmetto Drive 21040 Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 0 1 ☐ Yes 2 🗵 No Specify: þ 3 ₩ Widowed 4 Divorced White "natural" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) 3 U.S. Government Cook Department of Health and Mental Hygie Important; If Item 27 Is marked other I any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Morris Lane Doss Roxanne (nmn) Brewer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Farrington / Son 300 Palmetto Drive, Edgewood, MD 21040 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Mother (Specific ntombment 11-19-09 Air Memorial Gdn. Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the or ath. shock, or heart failure. List only one cause on each line whiter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Adomino, /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. (Disease or mjury that initiated events resulting in death) Last Examiner Due to (or as consequence of): be executed condonemo Due to (or as a consequence of): burial physician the burial Box 68760 Physician/Medical as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Dav Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sion of Vital Records. þ 1 Tyes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No I∐Yes 2∐No 25. Was case referred t edical examiner? 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical Medi and manner stated. 29d. Date signed Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08926 State of Maryland / Department of Health and Mental Hygiene Joyce Ann Ferger 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 17, 2009 0805 hrs **Medical Examiner** JOYCE ANN FERGER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Rol Air Upper Chesapeake Medical Center If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Min Davs Hours Country) New York Director Sep. 23, 1960 49 073-52-8315 Yrs 1 M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No 28a-f show Bel Air Maryland Harford notified at once, with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 303 Lakeside Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. White etc. 1 Never Married 2 X Married Armed Forces? death \ Yes 2 X No õ White Yes 2 X No specify: hours after 3 Widowed Divorced If Yes. Give Year permit. Pages I and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. <u>\$</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Automotive Sales 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Judith Ann Cassidy John Thomas Kepley æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Lakeside Drive, Bel Air, Maryland 21015 Stephen Ferger / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 11-23-09 Aberdeen, Maryland Memorial Gdn Donation 5 Harford Other Specify 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Inneral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or comp **Physician** failure. List only one cause on each line Medical a Acute bronchopneumonia Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlyin, Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last TT, 28a,b,f per ME g899 1/15/10 12/2/09 **23a,PII,27,permE,** #29d & 30 per ME Physician/Medical X UNPENDED X AMENDED has been signed by the attending physician 2 should be detached for use as the burial g898 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown ۾ Hypertensive atherosclerottic cardiovascular Completed 24a. Was an 24b. Were autopsy findings available disease; multiple sclerosis; urinary tract prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 certificate infection 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Residence 6 2 PER/Outpatient 3 DOA Nursing Home 5 Inpatient 1 ✓ Yes ٩ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural FOUND: 5 Pending Yes 2 No Nov 17, 2009 0700 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) (Specify) Homicide

the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi-npletely filled in by the funeral director, I To the Funeral

> Assistant Medical Examiner State 31. Date filed (Month, Day, Year) NOV 19

29b. Signature and title of certifie

29a. Certifier

Medical

111 Penn Street, Baltimore, MD 21201 egistrar's Signatur

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

OCME

Russell Alexander, MD

29d. Date signed (Month, Day, Year)

November 18, 2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Registra

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4. 2009 Physician 5:00 P M November 14, Peggy Lou Florence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🛱 F Oct. 14, 1937 Virginia 72 230-48-7858 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Inchesial Examinar must the mental in the second. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 ☐ No Directo Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20851 United States 504 Fletcher Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ella Maddox Aubrey R. Bailey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 504 Fletcher Place, Rockville, Maryland 20851 Gene Milton Florence/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairfax, Virginia Nov. 20, 2009 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park 21. Signaty of Funeral Service Lightsee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Chai loum 16. M01530 20850 300 West Montgomery Avenue, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Por Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛛 No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performed Hospital or Attending Physician: The 1 ☐Yes 2 ☐ No 1 ☐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice Hospital: 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Kouertchou November 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 201 East University Parkway Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 20 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#27perFH, G897, 11/20/09, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Year 30 a 200 mber /Medical Facility Name (If not institution, give street and number 4c. County of Death Examiner Himore marita ttospita rs. last birthday) Birthplace (State or Foreign Country) (In)rs. **Funeral** Days Months 1 □ M 2 🕶 F Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County Town or Location other traumatic event, the Medical Examiner must be notified at Baltimore 1 Wes 2 □ No Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number IUSA threnne 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Yes. Give Blac 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၀ 19b. Mailing Address (Street and Numbe ral Route Number Bal unningham Dr. \sqrt{C} regor Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposi gemetery, crema 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ame and Address of acility 6 (11 U 5/5/Balto. Natil 23a. Part 1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Kranen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes. 2 ☐ No 9 ☐ Onknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 🗌 No 3 Probably 4 Onknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 DER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 0 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) November Freentn, 29c. License number 29b. Signature and title of certifier 00 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 10 atr cia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .^{Day}009 Physician/ Elsie O. Garv М 7am Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3430 Juneway Baltimore If Under 1 Year If Under 24 Hrs. Date of Billing (Month, Day, Ye 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. WestVirginia June Director 214 26 3770 81 1928 Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director MD n/a Baltimore 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral with 23a 3430 Juneway 21213 USA items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. med Forces; ☐ Yes 2 ☐ No Yes Give X 1 Never Married 2 Married ō δ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify If Yes, Give "natural", 3√ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. narked other than Elementary/Seconday (0-12) College (1-4 or 5+) Nurse (LPN) Spring Grove Hosp vr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ Roy B. Johnson Sr. Willie Maude Jeffers and lis mi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Paulette Gates (daughter) 3430 Juneway Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 6 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 只Donation 5只OtheMSaciisoleum Nov.24,2009 Balto,Md Arbutus <u>Mem.Pk.</u> ture of Funeral Service Licensee 22 Name and Address of Facility
Calvin B. Scruggs Funeral Home 412 F St 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ EARS disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or iinjury Due to force a considuence of burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No
9 Unknown Month Year signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ cate has been sig page 2 should b 1 🗌 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျဉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined - Hospital or Medical Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar 30 Name and addr

31. Date filed (Month, Day, Year)

NOV 2

DANIEUE DEBELMAN MO

6701 NORTH CHAPLES ST, SOLITE 4165 BALTIMORE, MD 21264

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

		•	For State Registrar	State of Ma	•	artment of I ertificate of			giene Reg. No 2 (009	37233
Phys /Me	siciar edica	_	1. Decedent's Name (First, Middle, Las Esther A.	Gurry				2. Date of Dea Month 11/19/	Day	Year	3. Time of Death 5:49 am ^M
	mine		4a. Facility Name (If not institution, giv Glen Burnie Heal	e street and number) th and Reha	ab.	4b. City, Town, c	or Location of Death Urnie			nty of Death Anne A	rundel
Fune Direct			5. Social Security Number 215–03–6285 6. S	ex 7. Age □M 2—— F	(In yrs. last birthday 90 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Month, Day 4/17/1	, _{Year)} 919	9. Birth Cou	place (State or Foreign ntry) MD
Maryland a-f show fied at		TOL	Usual Residence of Decedent 10a. State MD Anne Ar		10c. City, Town or L	ocation cchard Bea	ach				10d. Inside City Limits 1 □ Yes ※ No
h with the 23a or 28g	-	runeral Director	10e. Street and Number 7921 Sea Bree	ze Drive		10f. Zip Code	21226		10g. Citizen o	of What Cou USA	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Iten 27 is marked other than "natural", or items 23a or 28a-f show any Iniuv or other traumatic event. In Medical Examiner must be notified at		2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1		Was Decedent of H If Yes, specify Cub 1 ☐ Yes ② No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-		lace - Ameri lack, White, cify: Wh	etc.
within 72 hc ene. than "natu		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+	(Giv	edent's Usual Occup e kind of work done DO NOT use retire HOMEMake:	during most of work d)	king	16b. Kind of	Business/Ir	
Id be filed Aental Hygirked other		10 pe C	17. Father's Name (First, Middle, Last) Louis Smith		I		18. Mother's Nam	race Nas		ame)	
and 2 shousaith and Nath And N			19a. Informant's Name/Relationship (Type. Print) Susan N. Babka / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, Cit 7921 Sea Breeze Drive, Orchard								,
Pages 1 ament of He ant: If Item			20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Cedar Hi	osition (Name of ematory or other pla 11 Cemete	ery 11/2	Date 23/2009		imore	MD
permit. Departr Importa	once		21. Signature of Fuperal Convice Licer	seeVictor P.	Doda,Jr	Charles I 501 East	ss of Facility L. Stevens Fort Aver	s Funera nue, Bal	l Home timore	, Inc	1230
Physicia /Medic	al		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hypa	he death. Do not e	-	-	or respiratory ar	rest,		Approximate- Interval Between Onset and Death
icate be executed physician and s the burlal-transit		eulcai EXallisties	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
Attending Physician: The law requires that the death certificat redeath. **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.** **Todath.* **T		riiysiciaiyimedi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of Live birth 2 4 Pregnant at t	Fetal death 3	☐ Ectopic pregnand	су			Date of deliv	rery Day Year
w requires that been signed to should be detailed	Ì	2	Part II. Other significant conditions of	ontributing to death but	-	underlying cause giv	ven in Part I.	23e. Did to			the cause of death? bably 4 Unknown
The law recate has be page 2 she	foliamo	nanihieren						24a. Was a autop perfor 1 ∐Yes	sy		opsy findings available ompletion of cause of 2 No
ysician: The scertificate director, pag	å	מ	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 Inpatien	t 2 ER/Outpatio	ent 3 DOA Oth	26. Place of Deat	th <i>(Check only or</i> ome 5 ☐ Resid		Other (Space	(6/)
eath. or: After this certific the funeral director,	F	- 1	27. Manner of Death 1	28a. Date of Injury (Month, Day,	Year) 28b. Time Injury	of 28c. Inju Wor M 1 L		28d. Describe h			97
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	ijita		4 Homicide determined	building, etc.	y - At home, farm, s (Specify)			City or Tow	n, State)		al Route Number,
the Hosp thin 24 hor the Fune	Modical	Medical	(Check only 2 Medical Examone)	nysician: To the best of niner: On the basis of and manner state	examination and/or	nvestigation, in my	opinion, death occur	rred at the time,	date and plac	e, and due	to the cause(s)
7 ₹ 5		-	290. Signature and the of certifier	<u>_</u>	- MD	230. Licent	D5159	16 N	loveml	ser 20	2009
	0.		29b. Signature and lite of certifie 30. Name and address of person who a company and address of person who are a company and a	completed cause of dea	ath (Item 23a) (Type	Print) Roo	id, 103,	alent	Some	ì, M	D 21061
	State istrar		NOV 2 0 20	09 Sineura	's Signature	arkal		App in the contract of the con			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4b. City, 76yn, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 6. Sex 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) Security Number Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🔃 Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10c. City, Jown or Location 10b. County 1. Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 V 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whitenetc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2□No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working the DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 sh 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Division of Vital 2 PNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 □Yes 2 □No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 com

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item_23a) (Type, Print)

DOL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WINDER Physician/ 2 VIVI9 Alice E. Holmes 01:57FM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Particle Days Hours Min. . Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birting. Country) VA **Funeral** 1 🗆 M 2 🛛 F Month, Day, Year 0 217-12-7550 86 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4800 Yellow Wood 21209 Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Black, White, etc African Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ☐ Yes 2 🖾 No δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American If Yes, Give Completed 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ctn. 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I life. DO NOT use retired) 12th Grade 2 vrs. Jewish Community Home maker t, Page 1 and 2 should be filed wit trment of Health and Mental Hygie rtant; If item 27 is marked other ' ijury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Holmes Cain Leonard Eliza Α. 19a. Informant's Name/Relationship (Type, PrinDaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Marva Braxton King 2508 Longwood Street Baltimore, MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 11-23-09 Woodlawn MD Wylie Funeral Home 21. Signifiure of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician/ CHRONIC LYMPHOCYTIC LEUKEMIA Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA HOURS Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, Exami SERSIS and-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown n signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident injury 5 Pending 1 Yes 2 🗌 No Investigation the ' 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who compl

31. Date filed (Month, Day, Year)

ER

W D

ed cause of death (Item 23a) (Type, Print)

7601

3 Registrar's Signature

Lieur

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DRIVE TOWSON, MARYLAND

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:50 A^M Andrew Higgins November 1, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Prince George's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2 □ F 24 Yrs. New Jersey 1985 141-78-1074 Jan 14, Director Usual Residence of Decedent 10d. Inside City Limits 1∩a State 10b County 10c. City. Town or Location show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified. 1 □Yes 2 □ No Director MD Prince George's Capitol Heights 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20747 USA 4409 Rena Road Apt. 203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technician Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Cummings Todd Higgins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 5228 Virginia Springs Court Clayton, OH Todd Higgins (Father) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages ' Department of important: if it any injury or o 1 Eurial 2 □ Cremation 3 □ Removal from State 11-7-09 Moraine, Ohio 4 ☐ Donation 5 ☐ Other (Specify) West Memory Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.H. Roberts Funeral Home Dayton, OH 45417 38 S. Gettsburg Ave /23a/Partl. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Werein+ 2775 of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner Exami aurfrena and Due to (or as a consequence of): burial-Box 68760, physician certificate be Physician/Medical for use as the signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 \subseteq Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I □Yes 2 □No 9 ☐ Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u></u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 6 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examine. 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Attending 5 Pending investigation MVA - CAK CROSSED into Oncoming
28f. Location (Street and Number or Flural Floute Number City of Town, State) 1 | Natural 13:45 1 ☐ Yes 2 ₩o 10-15-09 2 Accident
3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ö Allentown Rd @ Foratville Rd Hospital C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of the cause(s) and manner as stated of the cause(s) and manner as stated of the cause(s) modern manner as the cause(s) and manner as stated of the cause(s) modern manner as the cause(s) and manner as stated of the cause(s) and manner as 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

To the within 2

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

BAHMANYA

ORIGINAL

leath (Item 23a) (Type, Print)

3001

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fn 8898 12/4/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 18,2009 Physician/ 2:12 рм Ronald Ralph Hoobler Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Holly Hill Manor Nursing Home Towson 8. Date of Birth Feb . 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Felloning ay, 1942 219-40-1029 1 👿 M 2 🗆 F 67 MaryTand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21228 United States 12 Locust Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Social Security (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administration Computer System Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Loretta Demler Ralph Hoobler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harper Keech Fitzsimmons/Wife Catonsville, Maryland 21228 12 Locust Drive 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Vovenber 20, 2009 Metro Crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Wuneral Service License cremation Society of 299 Frederick Road Maryland, Baltimore; Inc. Marvland Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) Yes 2 No signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by 4 Unknown 1 Yes 2 No 3 Probably icate has been sig ; page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy performed 1 Yes 2 No prior to completion of cause of 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending Investigation
6 Could not be М Accident Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen C.__ 31. Date filed (Month, Day, Year) NNV 2 0 200 Eisen Stadt Keisterstown, MD N. 32, Registrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland / De	epa C <i>er</i>	rtment of He	ealth a Death	and Me		eng g. No.	009	37238
	Physici	an	Decedent's Name (First, Middle, L	ast)	20		-		1	2. Date of Death Month	Day	Year	3. Time of Death
	/Medic		Albert	Marca	25					November	_11	2009	5:54 P M
	Examir	ner	4a. Facility Name (If not institution, g				4b. City, Town, or				4c. C	County of Deat	
			Angel Touch Assisted 5. Social Security Number 6.		ge (In yrs. last birthe	rfa v l	West Frie			Date of Birth	ļ	Howard	
	Funeral Director		048-01-4998	1 ⊠ M 2□F	90 Yr		Months Days	Hours	Min.	B. Date of Birth (Month, Day, (ay 6, 191	Year)	Conn	nplace (State or Foreign untry) ecticut
	D		Usual Residence of Decedent							, ,			
	arylar show	Ļ	10a. State 10b. County		10c. City, Town								10d. Inside City Limils 1 ☐ Yes 2 🔀 No
	Ne W	Directo	Maryland Howard		Co.	Lum	bia						
	a or		10e. Street and Number	1			10f. Zip Code	. =		10	og. Citize	en of What Co	untry?
	feath	Funeral	6280 Loveknot P	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of His		ain? (Spec	ifv Yes or No-	14	U.S.A.	rican Indian,
٥	or iter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give	No No		Vas Decedent of His Yes, specify Cubar		, Puerto R	ican, etc.)		Black, White	e, etc.
3	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:	Army	1	☐ Yes 2XXNo	Specify:			3	Specify: Wh	ite
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מ		ပို	17. Father's Name (First, Middle, La.	st)	- Callina				r's Name (First, Middle, N		<u>.</u>	· · · · · · · · · · · · · · · · · · ·
and	Mental Mental rked c	To B	Louis Kardos					Ella	Varga				
a _Z	2 should be and Mental is marked reumatic ev	Γ	19a. Informant's Name/Relationship				g Address (Street a				-		(ip Code)
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More	nit. Pages 1 and 2 should be filed artment of Health and Mental Hyg ortant: If Item 27 is marked othe injury or other treumatic event.		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3	☐Removal from State		crem	natory`or other place		Da			ation - City or	
	tant:		4 □ Donation 5 □ Other (Spec	city)	Arlington	_	ational Ceme	-		010 A	rline	gton, Vi	rginia
Dalt	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Lic	nsee		Wit	Name and Addres zke Funera	s of Facility L Homes	s Inc		D 010		
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1	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) a. Ends Tage Dementia Due to (or as a consequence of):										Interval Between Onset and Death
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DIVISI	To the Hospital or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home, fam lc. (Specify)	ı, stre			28	Bf. Location (Str. City or Town,		Number or Ru	ral Route Number,
	he Hospit in 24 hours he Funera pletely fille	edical	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner st	of examination and/	death or inv	occurred at the time estigation, in my op	e, date and inion, deat	d place, ar	nd due to the ca d at the time, da	use(s) a ite and p	nd manner as place, and due	stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier	CRIS	9		29c. License	number	993	5	111	signed (Month	2009
	15		30. Name and address of person wh	o completed cause of	death (Item 23a) (Ty	/pe, F	Print)	100	Sto	6/5	11	*	MDZIOO
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	h	igijal.	NG	0 W	-1,01	rru	cum;	M 126/01()
	Registr		NOV 2 0 2009	General &	back	B	U						

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	1	For State Registrar	State o	f Marylaı	nd / Depa <i>Cer</i>	artmer <i>tificat</i>	nt of H	lealth a Death	and M	lental Hy	giene Reg. No	200) 9	37239
Physician/	•	1. Decedent's Name (First, Middle, a	•							2. Date of De Month NOV •			rear 009	3. Time of Death 5:05 p M
Medical Examiner	4	la. Facility Name (if not institution, g	ive street and num		na Home			Location o	of Death	Novi	4c	County of	Death	
Funeral Director		_		7. Age (<i>In yr</i> s. 6 !	last birthday)		r 1 Year	If Under Hours	Min.	8. Date of Bir (Month, Da May 4,	th 1944	1	9. Birthp Coun	olace (State or Foreign try) WA
aryland a-f show fied at	-		George		ity, Town or Loc	cation		_					1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
leath with the Maryland items 23a or 28a-f sho ler must be notified at Funeral Director	1	Oe. Street and Number 7005 Fitzpatric		200		1 '	p Code 0707				10g. Ci	itizen of Wh	at Coun	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	1. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed For 1 Yes If Yes, Give Year or Dat	ces? 2 KNo				spanic Orig n, Mexican Specify:		cify Yes or No- Rican, etc.)		14. Race - Black, Specify: W	White,	etc.
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and 2 shou Health and Pm 27 is rr Ther traum	L	19a. Informant's Name/Relationship David W. Kueker/ 10a. Method of Disposition	, , ,	Loo	7005	ng Address (Street and Number or Rural Route Number, City Fitzpatrick Drive, Laurel,				el, N	MD 20	707	<u> </u>	
it. Page 1 artment of h		1 ☐ Burial 2 ※ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	ecify)	State	Place of Dispo- cemetery, crem st Arun	natory or o	other place Crem	•	Nov 2	009 17,	Ođer	ocation - C	MD	
Department on the control on the con	21. Signature of Funeral Service Licensee 22. Name and Address of Facility DOI 313 Talbott Ave., 1 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac									aurel,N	1D 20		Home	, P.A.
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nysician; The la his certificate ha il director, page 2	2	25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo	Hospital:	npatient 2 🗆] ER/Outpatien	t 3 🗆 D	Otho	ace of Deat		only one) me 5□ Resi	dence 6	6 ☐ Other	(Specify	
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FSFÖ		> Ke	98			D	5656					ember		
State	ı	10. Name and address of person we Sunitha, Bhogav: 1. Date filed (Month, Day, Year)	illi, MD,	9801		a Ave	. Su	ite l	-17,	Silve	r Sp	ring,	MD	20902

State of Maryland / Department of Health and Mental Hygiene 37240 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician GREGORY VINCENT KUGLER 11:31 AM 2009 18, November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Ye June 19, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) ^{Year)} 1971 **Funeral** Months Days Hours Min. 1 ₹ M 2 □ F 38 Maryland Director 215-90-1974 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinas must be neithed at 1 Yes 2 □ No Director Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3017 Glenmore Avenue 21214 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CAD Draftsman Consulting Engineers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be and Menta John Joseph Kugler, Jr. Joan Marie Keenan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Laurie Kugler (Wife) 3017 Glenmore Avenue, Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 11/24/2009 Baltimore, Maryland 21. Signard of Funeral Solvier Vicensee 2007

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Multiorgan **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 / No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tit of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA SAVORIE 31. Date filed (Month, Day, Year) State Registrar

State Registrar

P.O.

Division

BON SECOURS

HOSPITAL.

DGO A

32. Registrar's Signature

1 - State Registrar	
1. Decedent's Name (First, Middle, Last) Anna Lebe	th

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	uneral irector	
land	wo #	

Labeth Anna 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death <u>5003 Morning Star Drive</u> Dayton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In vrs. last birthday) Social Security Number 6. Sex Date of Birth (Month, Day, Year) Days Months 1 □ M 2 🕅 F 92 215-57-3720 April Usual Residence of Decedent 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Mary nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sh ral", or items 23a or 28a-f sh Examiner trust be notified a Directo Maryland Dayton Howard 10e. Street and Number 10f. Zip Code 21036 Funeral 5003 Morning Star Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 👿 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Completed by 3 X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 7th 17. Father's Name (First, Middle, Last) Be ဥ Matsche Sekyra Franz 19a. Informant's Name/Relationship (Type. Print) 5003 Morning Star Drive Renate Frady/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee manuta Rahamas 1411 Annapolis Road 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzhamar 5 /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Hypertension Completed 24a. Was an autopsy performe 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 19, 2009 1)0061396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stevens Forest 1200d Suite 102 Columbia, NUD 21046 CVOSSE , My 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 2 0 2009

2. Date of Death 3. Time of Death 19, 2009 7:00A M November 4c. County of Death Howard Birthplace (State or Foreign Country) 10,1917 Czech Republic 10d. Inside City Limits 1 ☐ Yes 2 👿 No 10g, Citizen of What Country? Germany Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Factory 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dayton, Maryland 21036 20c. Location - City or Town, State 11/25/2009 Odenton, Maryland Donaldson Funeral Home & Crematory, P.A. Odenton, Maryland 21113 Approximate Interval Between Onset and Death 3 years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar DHMH 17 Rev 1/2001

			1- For Amend Item Registrar	State of Maryla 8 per fh, g9	06,08 <u>7</u> 8	4/2010di rtificate o	Health TDeath	and M	ental Hy	gier ie _{Reg. No.}	007	0,12
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day		3. Time of Death
	/Medic			ou Lay	ton	,			Novem		3, 2009	12:50 PM
į	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town	, or Location	of Death			County of Deat	
			5802 Annapolis Re 5. Social Security Number 6. Sex		() s. last birthday)	Blades If Under 1 Ye	nsburg	r 24 Hrs.	8. Date of Bir			George's
	Funeral Director		219-44-2367	M 2 F 64	Yrs.	Months Day		Min.	(Month, Da 10/23/	y, Year)	Co	cyland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation						10d. Inside City Limits
	Manyi	Į.	MD Allegar		rostbur	~						1 ☐ Yes 2 ☐ No
	28a	Director	10e. Street and Number	Iy F	rostbur	10f. Zip Code				10g. Citiz	zen of What Co	untry?
	h with		1221 Carlos Road	SW		215	32			US	SA	
	deet	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify C	f Hispanic O	rigin? (Spe	city Yes or No)- 1	14. Race - Ame Black, White	
8	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🕅 Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 🔀 N			noun, etc./		Specify:	
Ş	hour: tural'		3 Widowed 4 Divorced	Year or Dates:	162 Docco	dent's Usual Occ	upation				What of Business/	lite
215-0036	in 72	Completed	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use ret	ne during mo	st of workir	ng	100. Kii	id of business/	moustry
7	d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Sec	retary				Of	fice/Ho	tel
2	al Hygid d other	Bec	17. Father's Name (First, Middle, Last)				18. Moth	ner's Name	(First, Middle	, Maiden .	Sumame)	
Maryiand	ould b Ment	Tol	David John Morgar						. Spend			
<u>la</u>	2 sh and ie m reum	6	19a. Informant's Name/Relationship (Ty)			ng Address (Stre						(ip Code)
	1 and Health em 27 ther t		Lawrence Layton 20a. Method of Disposition	(Husband)		l Carlos			rostbur ate		D 2153 cation - City or	
altimore,	ages int of t: if it		1 Burial 2 □ Cremation 3 □ R	emovai irom State	. Place of Dispo cemetery, crer		1	_				
	ertme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License		rostburg 22	g Mem. E 2. Name and Add		11-11	wers Fu		ostburg	, MD
ä	permit. Pages 1 and 2 should be fil Depertment of Health and Mental H Important: if Item 27 ie marked ott any inlury or other traumatic even <u>once.</u>		Jan Br	and Oc				501	wers ft Main St			g, MD 21532
r			23a. Parti. Enter the disease, or compli	cations that caused the de	ath. Do not ent	er the mode of o					10000	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PANCRE	ATIC	CAN	CGZ					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
	or .	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	(3. 23 2 33.13	94401100 01/2							
o Î	exect en and rial-tra	Еха	resulting in death) Last	Due to (or as a conse	equence of):							
2/20	icate be executed physicien and s the burial-transit	dical	€ d									
0	ertifica ling pl	ω.	IF FEMALE:									
XO D	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregna				2	3d. Date of deli Month	very Day Year
j.	the de	yslc	1 ☐ Yes 2 ₹ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	rdeath 5	Other (specify)	-					,
7	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause	given în Part	1.	23e. Did t	obacco us	se contribute to	the cause of death?
cords,	quires an sign uld be								10	Yes 2	No 3∏Pr	obably 4XIUnknown
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	Page 1	Com							perfo	rmed? 2 X No	death?	
N I I I	Physicien: The this certificate rat director, pag	Be	25. Was case referred to medical exeminer?	ospital:					(Check only o			_Daughter's
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DIVISION	or Attending F after death. I Director: After d in by the funera	Hice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, str	eet, factory, offic	ю	2	8f. Location (Street and	d Number or Ru	ral Route Number.
5	itel or rs after el Dir led in	Certification:	, , , , , , , , , , , , , , , , , ,	building, etc. (Spe	··· <i>y</i>)				Ony 01 101	, J.(4(0)		
	To the Hospitel or Atti within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in m	time, date a y opinion, de	nd place, a	and due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the	Mec	29b. Signature and title of certifier	and mainer states.		29c. Lice	nse number			29d. Date	e signed (Monti	n, Day, Year)
) Im	MD		De	0057	798	4	Na	iember	20, 2009
			30. Name and address of person who co		em 23a) (Type,	Print)						
			LUIS DIAZ 1650	ORLEANS ST		I, B.	ALTIMO	see,	MD	2123	,	-
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	arkal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:05 P ^M 2009 Emma Rosina Langston November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3101 Cardinal Way Unit G Abingdon If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days **Funeral** 1 □ M 2 😡 F Yrs 1918 Germany 4. Director 91 452-62-5069 Usual Residence of Decedent is and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ral", or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2X No Director Abinadon Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 Unit G 3101 Cardinal Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. Completed by White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental I.
Important: If item 27 is markany injury or other Be Elisabeth (nmn) Vogt Johannes (unk) Beck ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 S. Parke Street, Aberdeen, MD 21001 Wilbur Bolton / Executor 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State George's Epis. Cem. 11-23-09 Perryman, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sim McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myscardin **Physician** Aute disease or condition resulting in death) /Medical Due to (or as a consequence 4) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) Ö 9 Hlnknown 9 Unknown ed by the ٥. signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No မ funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

10 V 2 0 2009 June S. Sach

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas No

31. Date filed (Month, Day, Year)

ORIGINAL

132. Registrar's Signature

Box Hill Corp. Cots my Abingdon, al. 21009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Diana Mitchell Lynn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F Months Min 216-11-7105 38 3/2/1971 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Wilson Blvd 21601 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telemarketing Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Balze Gale Carr Peter Paul Tressa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karol Hancock/ Grandmother 311 Wilson Blvd, Glen Burnie, MD 21061 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 11/19/2009 Hanover, Maryland 4☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licersee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final esoluti disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Wadical Event are rust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and hijury or other traumatic event, the Medical Event partmet be no once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Hospital or Attending Physician: The law requires that the death certificate be executed ician and buriaf-tran attending physician for use as the burial signed by the a certificate has been s rector, page 2 should director, After this 24 hours after death. e Funeral Director: A set of filled in by the fu

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ANO 1 □ Yes 2 -No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

A-JBULLINO

Net'1 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0017565

(2 Uzle, MD 21502

29d. Date signed (Month, Day, Year)

2009

To the Hosp within 24 hou To the Fune completely fi

			1 = For State State of Maryland Registrar		rtificate of			g. No.	01210			
Į.	Physici	en.	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death			
t	/Medic		Mary Lucille Rudd	Moo			Novembe	r 10, 2009				
	Examir	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Dea				
4.00	Y N		8517 Shorthills Drive	11:11:1-1	Clinton If Under 1 Year		10	Prince Ge				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Yrs.	Months Days	Hours Min,	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)			
	Director		Usual Residence of Decedent				Oct 19,	1921 Nort	th Carolina			
	yland yland at		10a. State 10b. County 10c. City, 1	Town or Lo	cation				10d. Inside City Limits			
	a-f st	tor	MD Prince George's Clina	ton					1 ☐ Yes 2 ☐ No			
	th the or 28	ire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C				
	23a ust b	ral	8517 Shorthills Drive		20735			USA				
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Merkeal Examiner must be notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am- Black, Whi				
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פ	_ 0 .	Be C	17. Father's Name (First, Middle, Last)		•		e (First, Middle, M					
yland		ToE	Ivory Rudd			Ada Lyn	ch					
Mar	s 1 and 2 should be f Health and Menta item 27 Is marked other traumatic ev	Ė	19a. Informant's Name/Relationship (Type. Print)					City or Town, State,	Zip Code)			
	es 1 and 2 of Health fitem 27		Barbara Moore Davis - Daughter			Oaks Dr.	Atlanta	, GA				
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place certification	e of Dispon netery, cren	sition (Name of natory or other plac	ce)	Date 2	20c. Location - City or	Town, State			
	. Pag tmeni tant: jury		4 □ Donation 5 □ Other (Specify) Rocky		nt Mem. I		14-09	Rocky Mou	int, NC			
ซ	permit. Pages Department of I Important: If ite any Injury or or		21. Signature of Funeral Service Lisensee	22	. Name and Addre	11.0		n Funeral				
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	Physician /Medical		Immediate Cause (Final disease or condition a. Stroke resulting in death)									
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<u>,</u>	executing and in all tra	Exa	resulting in death) Last Due to (or as a consequent	nce of):	·	. "						
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5	s afte	Certification:	4 Homicide determined building, etc." (Specify)				City or Town,	State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	the H in 24 the F nplete	Medical	and manner stated.	Tana or in			red at the time, da	tte and place, and du	e to the cause(s)			
	witl Con	2	29b. Signature and title of certifier Mary a Holdman	D n	29c. License D25		29	d. Date signed (Mon				
								11-12	-03			
			30. Name and address of person who completed cause of death (Item 23 Marcia Goldmark, MD Shady Gr			ille. MD						
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	9		,						
	Registr		NOV 2 0 2009 /2		a Manh							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2, Date of Death Month 11/14/2009 Physician/ Irene Morris 01:34 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number 410-36-2396 . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12/5/1920 88 Days Hours Country) 1 M 2 St Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State AL 10c. City, Town or Location Florence should be filed within 72 hours after death with the Maryland Director Lauderdale 1X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 140 Plantation Place 35633 USA Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Domestic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dan Patterson Belle Gilchrist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Roldan / Daughter 1700 Candleberry Court, Crofton MD 21114 20a. Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Memorial Gardens 11/20/09 Collinwood, 4 Donation 5 Other (Specify) 21. Sign fore of Funeral Service LicenseeVictor P. 122. Name and Address of Facility Charles L. Stevens Funeral 1501 E. Fort Avenue, Balti Home Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Pregnant at time of death i signed by the aid to be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 201 No 1 Tyes مِ I ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d, Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis Aexamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 Ce 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

23a) (Type, Print)

mpleted cause of death (Item

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 37248 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 17, 2009 Physician/ 10:15 AM CARL WESLEY MOORE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE GILCHRIST HOSPICE @ GBMC If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Days Aug. 21, 1937 West Virginia 1 XM 2 □ F Months Hours **Director** 209-28-3029 72 Usual Residence of Decedent 10a, State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c, City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Maryland |Baltimore Nottingham 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 4 Flintridge Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry iit. Page 1 and 2 should be moon artiment of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မှ Florence Winona Hostutler Edward (nmn) Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code)
4 Flintridge Ct., Nottingham, MD 21236 Judy Moore / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-19-09 Towson, Maryland Hilltop Service Corp. 4 Donation 5 Other (Specify) Signatura of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. 2 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final As bestos Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that better the cause of the Examine Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte in the past 12 months? Year Pregnant at time of death Month Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dimonory MAMIC OBSTAVETUTO 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 1 Tes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Tather (Specify) NOSP UP ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

10:14A

6701

NV

32. Registrar's Signatu

N. Charles ST TOWSON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HALLES

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 37249 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** NOVEMBER 2009 23:39 DAVID PAUL MARTIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 € M 2 □ F Director June 28, 1951 Maryland 220-54-9087 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Director Maryland Harford Jarrettsville 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 21084 3108 Rocks Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Body & Fender Repair 12 Owner & Operator Department of Health and Mental Hygie Important: If item 27 Is marked other I any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Eleanor Hamby Paul James Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Martin / Father 2200 Creswell Road, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Service Corp. 11-19-09 Towson, Maryland McComas Funeral Home, P.A. 23a. Pert1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MENOW /Medical Due to (or as a consequence 1) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown page 2 should Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 No Division of Vital 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NgYes 2 □ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mn 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

NIANZ TO SCHOOL DO SOO UPPER Chesopeake Drive, Bel Any, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

4b. City, Town, or Location of Death

4c. County of Death

10d. Inside City Limits

White

Day

2 🗆 No

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

1 - For State Registrar

4a. Facility Name (If not institution, give street and number)

/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans attending properties for use as the Š signed b been page 2 certificate has or Attending Physician: After this of funeral direction To the F

Harford House of Jubilee Assisted Living Fallston If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Director 175-05-0644 June 11, 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hours after death with 2278 Baldwin Mill Road 21047 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ò Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be figure 2 Be George (nmn) Lengle Mary (nmn) Barry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health attem 27 ls Marlin Larry Morgan / Son 2509 Chestnut Hill Road, Forest Hill, MD 21050 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Mem Gdn 11/16/09 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any reaching to furniculate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 1 □Yes 2 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 - Nursing Home 5 - Residence 6 NOther (Specify Asst. Living 1 Yes 2.₽No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Gillian Adams,

2020

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

104 Plumtree Road, Suite 102, Bel Air, MD 21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 15, 2009 **Physician** 8:15 A M JOHN ALVIN MORGAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Forest Hill Health & Rehabilitation Forest Hill If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 4 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Funeral 1 M 2□ F 1924 Maryland Director 214-24-1924 Usual Residence of Decedent 84 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 XNo Director Forest Hill Maryland | Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code , or items 23a or 21050 USA 109 Forest Valley Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify À Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any Injury or other traumatic months." Elementary/Secondary (0-12) College (1-4or 5+) State Government Second Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Augusta Sallmann John Ware Morgan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 2102 Ruffs Mill Road, Bel Air, Maryland 21015 Larry Hartley/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp. 11-19-09 5 ☐ Qther (Specify) 4 Donation 21. Signature Punera Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final disease or condition resulting in death) 512 **Physician** /Medical Due to (or as a consequence of): **Examiner** 15chemic Sequentially list conditions, if any, leading to immediate cause. Enter of Jerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner SCUF A burial-tran Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2****□No 1 ☐ Yes 1 ☐ Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours a

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Dr. David Dunn - 615 W. MacPhail Road, Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature MOV 2 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D32296

29d. Date signed (Month, Day, Year)

09-08941 Brian Meise Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rian Meise		State of Maryland / Department For State Certificate		d Mental F		eg, No.	200	9 3725
Physician		egistrar I. Decedent's Name (First, Middle,Last)			2. Date of Dea	ith		3. Time of Death
Medical Examine		Brian Michael Meise			Month Novembe			1911 hrs
	4	la. Facility Name (if not institution, give street and number) 730 Frederick Road	4b. City, Town, or Catonsville	Location of Dea	th		unty of Death imore Cou	
- Transport		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		If Under 24H	rs. 8. Date of Bi			thplace (State or
Funeral Director			Yrs. Months Days				Foreig	In Illinois
		212-78-7764 1 1 x M 2 F 52 Jaual Residence of Decedent	113.		(US) ZA()	1907		MARYLAND
any		10a. State 10b. County 10c. City, Town or L	ocation					10d. Inside City Limits
and show	5 L	Maryland Baltimore Catonsvil						1 Yes 2 X No
ne Maryland or 28a-f show any fied at once.	<u>.</u>	10e. Street and Number	10f. Zip Code			•	of What Cou	
death with the Maryland or items 23a or 28a-f she must be notified at once	2	101 Ingleside Avenue, Apt. A 11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of His	nanic Origin? (Specify Yes or N		ed State	ican Indian, Black,
The street and Number 10e. Street and Number 10f. Zip Code 10g. Citizen of What 10e. Street and Number 10f. Zip Code 10g. Citizen of What 10g. Citizen of Wh								
3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specific Spe							ecify: Whit	œ
5-0036 seed within 72 hours after tygene. other than "natural", the Medical Examiner.		duri	edent's Usual Occupating most of working life.			16b. Kind	of Business/	Industry
36 thin 72 te. than "r edical E	1 Sec.	Elementary/Secondary (0-12) College (1-4 or 5+)				Self	Employe	rd l
5-000 led withing tygiene, other the	najaidillo	17. Father's Name (First, Middle, Last)	struction Wor		ne (First, Middle,			
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f shi		William J. Rowen		Jame 0				
Z = 9 = 3	┋┞	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Stree					e, Zip Code)
imore, MD 2 Pages 1 and 2 shou nent of Health and N and 11 litem 27 is a nor other traumatic		William J. Bowen/ Father 19 V 20a. Method of Disposition 20b. Place of D	sposition (Name of cer	ue, Cator	sville, M	arylan	1 21228 ation - City o	Town, State
Ore, es 1 al of He If ite	- 1		or other place)		ember 18,			
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: Metro Co	matory. Inc.		009	Baltimore, Maryland ation Society of Maryland, Inc.		
Bal permi Depar Impo injuri		21. Signature of Funeral Service Licensee Amanda Heaston	299 Frederick	Road, B	altimore.	ciety (Marvlar	of Mary 1 nd 21 <i>22</i> 8	and, Inc.
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	nter the mode of dying,	such as cardia	or respiratory a	rrest, shock	or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. Gunshot wounds (2) of head at	nd right forearm					Death
		or condition resulting in death) Due to (or as a consequence of):						
T T	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	티크	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
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Box 68760, e death certificate be the attending physic ed for use as the burn	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			nanov		Date of delive onth	ry Day Year
cox 6876(eath certificate attending phy for use as the b	Sician/M	past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Other (Specify)	Ectopic preg	griancy	, ivi	Ontin	Day 16di
BO)	≥L	1 Yes 2 No 9 Unknown g Unknown						
that the	à	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I.	111			the cause of death?
ords, P w requires t us been sign should be o	9							autopsy findings available
ord aw req as bee	Completed				aut	opsy formed?		completion of cause of
Rec The licate h	5				1 ✓ Yes	2 No	1 🗸	
tal Recian: The certificate	g	25. Was case referred to medical examiner? Hospital: 1 Insertion 2 FR/Outp		e of Death (Che	ck only one)	Posidens	e 6 🗸 Oth	er: Scene
of Vi	<u>•</u>	1 Ves 2 No 1 Inpatient 2 Evolup 27 Manner of Death 28a, Date of Injury 28b, Tim		ury at Work?	28d. Describ			- Coole
ion of Vital Rectending Physician: The earth. The this certificate the funeral director, page	Certification:	1 Natural 5 Pending Nov 17, 2009 0000 h	rs 1	Yes 2 🗸 No	Subject sh	not		
Visic or Atte fter der Directo in by th	g	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office	building, etc.	28f. Location	(Street and	Number or F	Rural Route Number, City
Dital o	Ē	4 Homicide determined (Specify) Convenience Stor	e		730 Frederi	ck Road, (Catonsville,	MD
	Medical	29a. Certifier (Check only one) 2 Wedical Examiner: On the best of my knowledge, death one) 2 Wedical Examiner: On the basis of examination and/or investigation.	occurred at the time, o	date and place, a n, death occurre	and due to the ca ed at the time, da	use(s) and te and place	manner as sta e, and due to	ated. the cause(s)
To with To con	ğ	29b. Signature and title of certifier	29c. Licen	se number		29d. Da	ate signed (N	lonth, Day, Year)
		(a/111118)	0.0	.M.E.		Nove	mber 18, 2	2009
	-	30. Name and address of person who completed cause of death (Item 23a)	7		04004			
			Penn Street, Bal	itimore, MD	21201			
Sta Registr		31. Date filed (Month, Day, Year) 32, Registrar's Signature	Care.					
. Kogioti		V 47	64					

Physician /Medical

Examiner

Physician/Medical

ģ

Completed

Be

2

Certification:

Medical

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Tillnknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 🔀 Natural

2 Accident

3 ☐ Suicide

4 Homicide

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brain Stem Stroke Due to (or as a consequence of) Due to (or as a consequence of)

Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4√ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

5:55a.m.[™]

Cuba

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic coronary artery disease

21. Signature of Funeral Service Licensee Amanda Heaston

1 🙀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an autopsy perform 2**K** No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 29b. Signature and title of contifier

5 Pending investigation

6 ☐ Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

2009

299 Frederick Road, Baltimore, Maryland 21228

22. Name and Address of Facility Cremation Society of Maryland, Inc.

D55861

11/12/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdul Munim, M.D., Laurel Regional Medical Center, 7300 Van Dusen Road, Laurel, Maryland 20707

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08876 State of Maryland / Department of Health and Mental Hygiene Harry McDonald, Jr. 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 15, 2009 1545 hrs Medical Examiner Harry McDonald Jr. c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Parkville 8311 Loch Raven Boulevard 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min Months Days Hours Country Maryland Director March 17.1960 49 219-76-8876 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 X No 23a or 28a-f show notified at once. Parkville Baltimore Marvland death with the Maryland Director 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number 21234 8311 Loch Raven Boulevard Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Dages I and 2 should be filed within 72 hours after the control of Health and Montal Hygiene.

Tant: If item 27 is marked other than "natural" and White 4 X Divorced Give Year Yes 2 X No specify: Specify: 3 Widowed 79-83 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the Medical Baltimore, MD 21215-0036 Automotive Repair Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delores C. Saylors Be Harry T. McDonald, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 935 Dunellen Drive Towson, Maryland 21286 Harry T. McDonald. 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 11/17/09 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify: ²² Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Thomas Gregor Inc. Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and Medical Death Oxycodone intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 28a per ME g898 12/29/09 23a,27,28a-f,per ME G898 Physician/Medical X UNPENDED X AMENDED tending physician a r use as the burial -/21/09 TT Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) for 1 Yes 2 No 9 Unknown q Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Records, P. Completed 24b. Were autopsy findings available 24a Was an been prior to completion of cause of autopsy performed? death? certificate has 1 Yes ✓ Yes 2 No. 2 No 26 Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other-Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification Natural Yes 2 X No subject ingested oxycodone Pending within 24 hours after death.

To the Funeral Director; the i 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) 8311 Loch Raven Blv Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 3 Could not be Suicide determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier November 16, 2009 O.C.M.E.

31. Date filed (Month, Day, Year) State Registrar

Assistant Medical Examiner 32 Registrar's Signature

30 same and address of pers o completed cause of death (Item 23a)

Russell Alexander MD.

MUADU

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f Per FH G897 11/20/09 Jh State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician QUEEN VICTORIA 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESA PEAKS LORD Gedical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 212-28-6076 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show Department of Health and Mental Hygiens in the result of Health and Mental Hygiens in the result of Health and Mental Hygiens in the result of Health and Mental Hygiens in the result of the result o 1 ☐ Yes 2 No Directo ar wood 10g. Citizen of What Country? 10f. Zip Code 21040 10e Street and Number U.5.19 21014 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Black 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 45525TAN] 05/71/AL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OTHER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 the wood, awaman Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1,2004 wallANN, 21. Signature of Funeral Service Licenses PROLINE 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ar Physician disease or condition resulting in death) */Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Queen Victoria m800518 Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 3 ☐ Probably 4 ☐ Unknown 2 🗌 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 100 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, by the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FR/Outpatient 3 DOA Medical Certification: To yes 2□No 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig DO036487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. 500 Upper Chesapeake Dr. Bel Air, MD 32. Registrar's Signature Steven Bentman, M 31. Date filed (Month, Day, Year) State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vovombor 10 200 1010AM Vondalear C. Neverdon 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Balto Seasons Hospice Randallstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 214-54-5106 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1 □ M 2/CXF MD 58 11-22-1950 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1√Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1102 Druid Hill Avenue 21201 U S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □Yes 2√No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes XXNo Specify 3 X Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) /a Elementary/Secondary (0-12) Disabled Disabled 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ester Ferrell James King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 67228 19a. Informant's Name/Relationship (Type. Print) Wichita, Kansas 2410 N. Graystone Street Corenthia Waller-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Memorial 11-21-09 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State Arbutus, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee MD 21202 Balto, ade Wa 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consciuence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🙀 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 M Other (Specify)

The law requires that the death certificate be executed physician and the burial-transi attending pl P.0. been signed be should be deta Division of Vital Records, cate has t page 2 s

To the Hospital or Attending

certificate this After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

Examiner

Funeral

Director

should be filed within 72 hours after death with the Maryland

Pages 1 and 2

permit. Page Department o Important: If any Injury or

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at

/Medical

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🐼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLD COURT ROAD RANDALISTOWN MO Burton 1) eborah 5401 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 1:55 P^{M} November Ruth C. Novak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Hours Min. June 2, 1918 Pennsylvania 195-03-2933 91 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. The strength and Mental hygiene are a strength or items 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1X Yes 2 ☐ No Maryland | Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7220 Chestnut Street 20815 U.S.A. Was Decedent Arroad Forces?

1 Arroad Forces?

1 Arroad Forces?

1 42 43 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna M. Froess Stephen E. Urban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7220 Chestnut St., Chevy Chase, MD 20815 Edward P. Novak (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/27/09 Trinity Cemetery Millcreek Township, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brugger Home for 1595 West 38 St. 21. Sign ure of Huneral Service Lice Funerals Erie, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonery Discuse Physician/ disease or condition resulting in death) hronic Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a some equation of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linlury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be Nounk, Ruth 11/13/09 1355 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Year Month 5 Other (specify) 1 Yes 2 9 Unknown be detached by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician:
Within 24 hours after death.

To the Funeral Director: After this certifications. 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 WNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 66996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Dr. Leonard,

Registrar's Signatur

8600 Old Georgetown Rd. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
June Navagrockis 2. Date of Death Day Year Month **Physician** 7:30 PM NOVEMBER 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
76 Yrs. Birthplace (State or Foreign Country) Social Security Number · 1933 **Funeral** 223-48-6241 1 □ M 2X F Months Days Hours Virginia Nov. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show id 2 should be filed within 72 hours after death with the Maryla. It and Martal Hyglens that the Maryla is marked other than "natural" or items 23a or 28a-f show tranmatic event, it a feeting the marked of the result is a feeting to the control of the marked of the ma 1 □ Yes 2 No Director Maryland Baltimore Arbutus 10g. Citizen of What Country? 10e Street and Number 1005 Stormont Cir. 10f. Zip Code 21227 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Was Decedon. _ Armed Forces? 1 ☐ Yes 2 🔥 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thorea C. Johnson Selby H. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Rausch, daughter 1005 Stormont Cir. Arbutus, MD. 21227 item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 Burial 2 □ Cremation 3 □ Removal from State MD National Memorial Park 11-18-2009 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lower Extremities of **Physician** bangrene - DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner teriphece Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I∐Yes 2**X** No 1 ☐ Yes 2 🗹 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ol or Attending Fafter death.

Director: After 1 Natural 5 Pending investigation 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760 グイフ在でからのだっろ

Baltimore, Maryland 21215-0036

0 State Registrar

DHMH 17 Rev 1/2001

HASAN AWAN 31. Date filed (Month, Day, Year) 20

M.O

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2006586

RO

29d. Date signed (Month, Day, Year)

BALTIMORE, MO 21227

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland 1 - State Registrar	Department of Health and Mental I Certificate of Death	Hygiene Reg. No. 2009 37259
J. P. S. B.	Decedent's Name (First, Middle, Last)	2. Date o Month	Dav Year
Physician /Medical	Leonard C. Ogden		mber 6 2009 2343 M
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
C'	Good Samaritan Hospital	Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. las.	t birthday) If Under 1 Year If Under 24 Hrs. 8. Date of (Months Pres.) When the Days Hours Min. Transcription of the Company o	f Birth 9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	June	2, 1949 Pennsylvania
land t		Fown or Location	10d. Inside City Limits
Mary -f sh fled a	Maryland Bal	timore	1 May Yes 2 □ No
vith the Mar or 28a-f sl be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h with	4224 Parkmont Avenue	21206	U.S.A.
firer death v ritems 23a inner must	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, .) Black, White, etc.
V.F.	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2X No Specify:	Specify:
1215-0036 virbin 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Me Ical Examiner must be notified at ompleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Decedent's Usual Occupation	White 16b. Kind of Business/Industry
n 72 n 72 le lice	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)	
than the Man	Elementary/Secondary (0-12) College (1-4or 5+)	Nursing	L.P.N.
nd 21215-00 oe filed within 72 hou tal Hygiene. do dother the Me 'call Event, the Me 'call E Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	iddle, Maiden Surname)
ylan ylan ylan wental wental arked o	Howard Ogden	Ruth Kreger	
Maryland Maryland d 2 should be file th and Mental H T Is marked out traumatic even To Be	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
and 2 salth 127 is er tra		145 Lynd St., Blossburg, PA	
of He of He	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of Date netery, crematory or other place)	20c. Location - City or Town, State
altimol	4 □ Donation 5 □ Other (Specify) Arb	on Cemetery 11/12/09	Blossburg, PA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. To Re Completed by Funeral Director To Be Completed by Funeral Director	21. Signiture of Funeral Service Lightse	22. Name and Address of Facility Pepper Funeral Home P.O. Roy 173 Capton P	A 1772/
	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	P.O. Box 173, Canton, P Do not enter the mode of dying, such as cardiac or respirat	on arrest Approximate
Physician	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	cardial infurction	Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) a. Due to (or as a conseque	nce of):	1 hour
Examiner			
The state of the s	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	new utty	
5), executed mand ial-transit Examiner	it any, leading to inimediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of the con		1
		nce or).	
38760, icate be exception as the burial-	d		
X 6 certific ding p	IF FEMALE: 23c. If yes, outcome pf pregnand	cy	23d. Date of delivery
Vision or Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certificate has been signed by the attending by the funeral director, page 2 should be detached for use as fireation: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	leath 3 ☐ Ectopic pregnancy	Month Day Year
the dy the ched	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		
Division or Vital Records, P.O i or Attending Physician: The law requires that the after death. I Director: After this certificate has been signed by the din by the funeral director, page 2 should be detached in by the funeral director. Be Completed by Phys	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
rds quires in sign uld be			1 Yes 2 No 3 Probably 4 Onknown
al Record The law requir cate has been s page 2 should		24a.	Was an autopsy findings available prior to completion of cause of
Rec		1 1 1	performed? death? Yes 2 No 1 Yes 2 No
Vital F vician: Th certificate rector, pag	25. Was case referred to medical	26. Place of Death (Check	
Or Vi	1 Yes 2 No Hospital 1 Inpatient 2 ☐E		Residence 6 ☐Other (Specify)
On O Jing Pt I. After th funeral	27, Manner of Death 28a, Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	Injury Work?	cribe how injury occurred
isiol Nttendil death. ctor: A y the fu	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home	M 1 Yes 2 No	tion (Street and Number or Rural Route Number,
t	4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factory, office 28f. Loca City	tion (Street and Number or Hural Houte Number, or Town, State)
pital potal potal potal control of filled in f		ledge, death occurred at the time, date and place, and due	to the cause(s) and manner as stated.
Division or Vital Reports to the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only 2 Medical Examiner: On the basis of examination	on and/or investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	> Dundel/ X	038543	November 6,2009
	30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)	7 1/ 21239 / /
26	Kenn H. Scruces MM 5601	Lach Kaven Bullerand	But more, Maryland
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	29c. License number D 3 9 5 4 3 23a) (Type, Print) Lech Paven Benfertwel ure D. Jackson	
negistiai	MUI & U LOUP CONTRACTOR	1 17	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Month 0856 AM **Physician** SOCIO 2009 Jominic November 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country) 2002 Maryland 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) **Funeral** Year 1 XM 2 □ F Yrs 7 214-65-7869 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐ Yes 2X No Director Harford Maryland Bel Air 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö USA 21015 247 Mary Jane Lane Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ☐ Yes 2 X No 3altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 📉 No Specify <u>Ş</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Public Education Student other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental I Nicole M. Spagna Chris Thomas Osorio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 247 Mary Jane Lane, Bel Air, MD 21015 Nicole Spagna / Mother Health em 27 i 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ō Department of Important: If its any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery 11-18-09 Darlington, Maryland 4 Donation 5 Other (Specify) uneral Service License 21. Signature of 22. Name and Address of Facility 12 McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

ased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 1 Enter the disease or complications th Approximate Interval Between shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final **Physician** grade DIOMA 24 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 🗌 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Tes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 1 ☐ Yes 2 No Hospital: 1 hpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

Box 68760 of Vital Records. Division after death. in by within 24 hours a completely

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier n. 8(4

29c. License number

MD 037357

29d. Date signed (Month, Day, Year)

November 13, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRALI N SHAH, MO THE Hospita

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

DHMH 17 Rev 1/2001

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 30 per dvr., g897 L1/23/09dbb
Reg. No.
Reg. No. Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Year Day Month **Physician** 200 (ou) /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Homes 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Min. 10M 20 F Months Days Hours Yrs. 509-26-2383 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Maricel Examin ermust be retiffed at once. 1 Nes 2 No timero Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \) 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ ₩o If Yes, Give Year or Dates Specify: Black Specify: þ 3 Mildowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchant Shoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/09 Galtimou 4 □ Donation 5 □ Other (Specify) -10 Y 22. Name and Address of Facility 21. Signature of meral Service Licer Ave Bg. 1+0. MD 21207 H007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 □ Yes 25. Was o se referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 I Nursing Home 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the to 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number of death (Item 23a) (Type, Print) 30. Name and addre Do 2435 West Belvedere Ave., Balto., MD 31. Date filed (Month, Day, Year, Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20ˈ0̈̈̈̈9 12:00 PM November John Bernard Pe1key Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 9415 Trevino Terrace Laure1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye 1 X M 2 - F Months Days Hours Wisconsin 1946 Director 62 389-50-4286 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2 X No MD Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9415 Trevino Terrace 20708 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 10 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) NSA Dept. of Defense Analyst event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene LaBelle Bernard Pelkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9415 Trevino Terrace, Laurel, MD 20708 Mrs. Janet Pelkey / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State any injury or Atlantic Crematory Nov.20, 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun all Pervice Licensee Gary L. Kaufman Funeral Home @ Meadowridge Mem.
Park, Inc. 7250 Washington, Blvd, Elkridge, MD21075 100804 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) 420 Medical Due to (or as a sequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 4-113 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 107

Registrar

State

trught

31. Date filed (Month, Day Year)

Charte

32. Registrar's Signature

Gozo, Columbia,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 14^{ay} 2009 4:45 A M James Irvin Philmon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 8436 Braddock Way Columbia . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Days Hours July 3, 1955 1 X M 2 🗆 F 219-68-4218 54 Washington, DC Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 K No Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8436 Braddock Way 21046 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 🗓 No Maryland 21215-0036 1 Yes 2x No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) Department of Defense Computer Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irvin Philmon Doris Grahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21046 Merry Martin (Wife) 8436 Braddock Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11-19-2009 Glen Burnie, Maryland 2, Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 2da. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Reital Pnysician/ Admolarimona disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Failure Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed? Yes 2 No this certificate 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30573 11-16-69 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon K. Minford, M.D. 10710 Charter Drive Suite GO20 Columbia, Maryland 21044

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me State Certificate of Death	ental Hyg	iene N2 1 1 9	37264
•			- Togata	2. Date of Deat	h	3. Time of Death
	Physicia		Frances A. Penta	Nov. 12	Day Year 2009	5:40 PM
e,	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1011 12	4c. County of Dea	th
i	Examini	eı	Lorien Mount Airy Mount Airy		Carroll	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		Months Days Hours Min.	(Month, Day, Dec. 31	. 1915 Mas	sachusetts
	~		Usual Residence of Decedent			
	ylan ylan at		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsl ified	cto	Maryland Carroll Mount Airy			1 ☐ Yes 2 ☑ No
	or 28 e not	Directo	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	ountry?
	th wil		4106 Vickie Lynn Court		U.S.A.	
	dea ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	city Yes or No- lican, etc.)	14. Race - Ame Black, Whi	
٥	after or ite mine		1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify:	
\mathbb{F}	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	d by	3 N Wildowed 4 □ Divorced Year or Dates:		W	hite
ភ	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of workin life. DO NOT use retired)	g	16b. Kind of Business	/Industry
2	vithin ne. han	ם	Elementary/Secondary (0-12) College (1-4or 5+)		Insurance	
7	led v Hygie her t	ပိ	12 Transcriptionist 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name	/First Middle II		<u> </u>
ב	be fi	Be	Charles Doherty Anne McB			
Ĕ	ould d Mei narke	7	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural		City or Town State	Zin Cada)
Maryland 21215-0036	12 sh h and 7 Is n traun				•	zip ooue)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Charlene A. Penta (Daughter) 4106 Vickie Lynn Ct., M 20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or	Town State
Ö	ges If of I		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		,	
	t. Pa tmen tant: ijury		4 Bollaton Shother (openly)		Haverhill	., MA
Baltimore,	permit. Pages. Department of I Important: If ite any Injury or of		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Costello Funeral Ho 177 Washington St.,	me Winche	ster, MA (1890
В			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line.		·	Approximate Interval Between
	Physician	1	Immediate Cause (Final		Onset and Death Day	
1	/Medical		disease or condition resulting in death) a. Urinary tract infection with Sepsis Due to (or as a consequence of):			Bay
	Examiner		Acute Renal failure		Day	
	16.5 E	Je.	Sequentially list conditions D.			
	cuted Id ansir	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Hypertension with Congestive Heart	failure	!	Yrs
Ċ,	an ar rial-tı		resulting in death) Last Due to (or as a consequence of):			
8/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d. Osteoporosis			Yrs
٥	ng pl	Med	IF FEMALE:			
. Box	eath certific attending p	an/	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year
	e des he at	sici	1 Yes 2 XNo			
J O	N requires that the deben signed by the should be detached	Physician/Me	9 Unknown	23a Did to	hacco use contribute	to the cause of death?
Ś	es th igned	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			Probably 4 Unknown
5	requi	ted	Gait Disorder, Cerebral vascular accident with	, ,	e3 2 140 5 1	
ပ္ပ	law l as be	Completed	Hypophonia	24a. Was a autops	sy prior to	utopsy findings available completion of cause of
r	The ate h page	no.		performula 1 ☐ Yes	med? death? 2 XNo 1 ☐ Ye	
Vital Records,	ctor,	Be (25. Was case referred to medical examiner?	(Check only on	re)	
2	ohysician: The lav this certificate has al director, page 2	입	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Hon		ence 6 □Other (Sp	ecify)
0	ding Phy h. After thi funeral (1 K Natural 5 □ Pending (Month, Day Year) Injury Work?	8d. Describe h	ow injury occurred	
<u>Ö</u>	endil sath. or: A he fu	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division or	I or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (S. City or Tow	treet and Number or F n, State)	Rural Route Number,
	urs al era! E		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the o	ause(s) and manner	es stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I.	Medical	29a. Certifier (Check only one) 1			
	o the	Mec	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	nth, Day, Year)
	FSFö		Maria Parilla Maria	۱,	Nov 16, 20	ng
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	NOV 10, 20	
			Allen Reilly, MD 801 Toll House Ave., D-1, Frederick.	MD 2	1701	
	Sta	ite				
N.	Regist		31. Date filed (Month, Day, Year) 32. Register's Signature NOV 2 0 2009 Denous S. Jacks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2009 Angela Marie Pozaro 9:00 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 245XF Months Days Hours 01 / 14 / 1928 Mary Land Director 216-24-8003 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam<u>iner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 🗆 Yes 2 🄀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 955 Kayden Lane 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Clerk State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Senft Lola May Pentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Patrick Michael Pozaro (Son) 3325 Holly Court, Falls Church, Virginia 22042 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Ind 11/23/2009 |Baltimore, Maryland 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Sender Licenses Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedine Cause (Final disease or condition resulting in death) Physician, CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 1 ☐ Yes 2 æ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27 Manner of Death Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check are To the best of my knowledge. Setti date and clane, and due to the causels) and than her as state 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) int 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD, MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Sk State Registrar

a.m.

00:6

19,

NOVEMBER

ANGELA POZARO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar		artment of Hea rtificate of Dea			iene g. N 2 0 0 9	37266
	Dhysisia		1. Decedent's Name (First, Middle, La	<i>'</i>				Date of Death Month		3. Time of Death
	Physicia /Medic	al	Elva M. Pittil			4b. City, Town, or Loca	ation of Dooth	Novembe	er 17 200	
	Examin	er	4a. Facility Name (If not institution, give Charlestown Care		ville			timore		
	Funeral		Social Security Number 6. 8	ex 7. Age	8. Date of Birth (Month, Day,	Year) 9. I	Birthplace (State or Foreign Country)			
	Director		215-12-0254 Usual Residence of Decedent	UM 200 F 8	8 Yrs.	Months Days He		06/02/1	921 B	altimore, MD
	yland how		10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits
	8a-f s	ctor		imore			onsvill			1 ☐ Yes 2 ☐ X No
	a or 2	Dire	10e. Street and Number709 Maiden Choice	Iana DCC21	0	10f. Zip Code 212	20	1	0g. Citizen of What	
	death	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of Hispar f Yes, specify Cuban, M		ecify Yes or No-	14. Race - A	States merican Indian,
5-0036	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Evanther rust be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:			pecify:	riican, eic.	Black, W Specify:	White
		Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)			16b. Kind of Busine	ss/Industry
1212	filed within Hygiene. other than "	dmo;	Elementary/Secondary (0-12)	College (1-4or 5+)		retary			Federal	Government
מ	filed THy othe ent,	Be C	17. Father's Name (First, Middle, Last)	-	18.			Maiden Surname)	
Maryland	2 should be f n and Mental is marked o raumatic eve	ျှ	William Eichhorn	T 0/	4 Oh - Marilla	ng Address (Street and i		B. Deave		a Zin Codo)
			19a. Informant's Name/Relationship (Nancy A. Abell (D			Castlebay				
altimore,	of Health of Health Fitem 27		20a. Method of Disposition			sition (Name of natory or other place)			20c. Location - City	
Ĕ	Pages treent of I tant: If ite		1 ☐ Burial 2 ♣ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Bayview (Crematory				e, Maryland
Rail	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lipe	nsee		2. Name and Address of 4107 Wilken	· пи		uneral Ho imore, Ma	me, Inc. ryland 21229
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	/)					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence of):	Mirson	au	rense		
	Examiner			bue to (or as a	consequence or).					
	sit sd	iner	Sequentially list conditions, it is any set in the cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
þ.	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
58760,	tte be o	edical E		_d						
_	certificate be executed adding physician and use as the burial-transit		IF FEMALE:	00 1/1						
O. Box	after for t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ν, σ,	w requires that the de to been signed by the should be detached	by Ph	Part II. Other significant conditions	/ /	071		Part I.	23e. Did tol	bacco use contribut	e to the cause of death?
ğ	equire			17/10	rlense	n		1 🗆 Ye	es 21 No 3	Probably 4 Unknown
Vital Records,	The lan ate has bage 2	Completed						24a. Was a autops perform	sy prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
VIta	ding Physician: The In. After this certificate hit	Be	25. Was case referred to medical examiner?	Hospital:		Othor:		(Check only on		
ō	y Physer this eral di	2.1	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	t 2 ER/Outpatier 28b. Time o	f 28c, Injury at			ence 6 Other (S	Specify)
õ	ending ath. ir: Afte	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	Work? M 1 ☐ Yes	2 □No			
DIVISION	al or Atte s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Si City or Town		r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical ((Check only 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	examination and/or in ed.	vestigation, in my opinio	on, death occurr	red at the time, o	cause(s) and manne date and place, and	er as stated. due to the cause(s)
)	To t To t	×	30. Name and address of person who sale filed (Month, Day, Year)	all	M	29c. License nu	race 4	20 2	29d. Date signed (M	Ionth, Day, Year)
	16		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)	mel	ary 1	aton	urlleg Md
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 0 20	19 A. Registrar	's Signature	Mad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 G. Riddell Helen 12:15 A M November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral June 8, 1923 1 □ M 2 □XF Months Mary Land Director 216-16-2471 86 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21222 USA 6907 Fenway Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important, If item 27 is marked other than "naturaly injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Feeheley Frank Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Riddell son 10 Zachary Joseph Court, Port Deposit, MD. 21904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 X Burial 2 Cremation 3 Removal from State Meadowridge 4 Donation 5 Other (Specify) 21,2009 Halethorpe, MD. Signature of Meral Service Licens Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stroke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to an include cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🗡 No Month 5 Other (specify) Dav Year Pregnant at time of death 1 Yes 2 2 9 Unknown been signed by the should be detached P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform this certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No 4 Nursing Home 5 Residence 6 N Other (Specify) HOS IN VCC ည 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💹 Natural 5 Pending 1 🗌 Yes 2 🗌 No □ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10 TO 29b. Signature and title of certifier 29c. License number Man R149194 November 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Towson, MD 21204 Marian Grant, 6701 31. Date filed (Month, Day, Year)

State Registrar

12:15AM

11/13/09

Riddel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	iryiano /		ificate of L		мена пу	giene Reg. No. 2	009	37268
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Dea	Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, gi	Relley			4b. City, Town, or	Location of Deal	November		2939 unty of Death	03-35 AM
g.gr	Examin Funeral Director	ier	Johns Harking Bay 5. Social Security Number 6/	view Medica	(In yrs. last to	oirthday)	RIV	If Under 24 Hrs Hours Min	8. Date of Birt (Month, Da	th	9. Birthp	
	D		Usual Residence of Decedent						Apr. 1	, 1916		
	shov	5	10a, State 10b. County		10c. City, To		ation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Harford		Edger	wood	10f. Zip Code			10g. Citizen	of What Cour	
	h with		1827 Steven Dri	ve			21040			USA		
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Exaction rules be coulded at	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ▼Yes 2 □ N If Yes, Give			as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sn, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify:	
2-0036		ed by	3 Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:			nt's Usual Occupa	ation			Wh.	ite
212	within 72 ho iene. than "natu	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	-1	(Give ki	nd of work done d O NOT use retired	luring most of wo	rking	TOD. TAILE	Dusiness/iii	uusti y
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Maryland	be ev	Be	17. Father's Name (First, Middle, Last Harry (unk) Atwo	_					me (First, Middle,		name)	
Ž	should ind Mel i marke umatic	은	19a. Informant's Name/Relationship		19	b. Mailing	Address (Street a		lla Relye		wn. State. Zic	Code)
	s 1 and 2 should f Health and Mei item 27 is marke other traumatic		Brenda Brubaker		1	_	Steven D				and 21	
altimore,	tges 1 and tof He: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place cemet	of Disposit ery, crema	tion (Name of tory or other place	e)	Date		on - City or To	
Ĕ	Pages tment of tant: If it jury or o		4 □ Donation 5 □ Other (Speci		Hillt		ervice C		L-19-09		n, Mary	yland
Ra	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lice	as Remot		13	17 Cokes	bury Roa	ome, P.A.	idon.	Marvla	nd 21009
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each line	the death. Do	not enter	the mode of dying	g, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between
E.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Care	diac a	arres	+					Onset and Death
	/Medical Examiner		1	Due to (or as a	consequence	. 3	art Fa					18 1/2 =
1		Jer	Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to for each	consequence		ar la	i w			7.1	10 /ears
	ecuted Ind transit	Examiner	that initiated events	c								
Ď,	rificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence	e of):						
08/PN	ficate physics the l	edical		d				.				
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal dea		Ectopic pregnancy Other (specify)	/		23d.	Date of delivened Month	ery Day Year
ī.	that the		Part II. Other significant conditions	contributing to death but	t not resulting	in the und	erlying cause give	en in Part I.	23e. Did to	obacco use	contribute to the	he cause of death?
Kecords	requires been sign should be	eted by								res 2 ☑ N		pably 4 Unknown
итан же	n: The law ficate has n, page 2 t	Completed	OF Was seen referred to a which	T - · ·					1 ☐ Yes	rmed? 2 N o	4b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
5	ysicia is cert directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	nt 2 🗆 ER/C	Outpatient	3 □ DOA Othe	ar:	ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Specif	(v)
VISION OF	nding Phy tth. r: After thi e funeral c	ation: To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day)		Time of Injury	28c. Injury Work	/ at	28d. Describe h			у)
DIVIS	ial or Atte s after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, (Specify)	farm, stree	t, factory, office		28f. Location (S City or Tow		umber or Rura	al Route Number,
	ne Hospi n 24 hour ne Funer oletely fill	Medical	29a. Certifier 1 ✓ Certifying Pi (Check only one) 2 Medical Example 1	nysician: To the best o miner: On the basis of and manner stat	examination a	ge, death o and/or inve	occurred at the tinestigation, in my op	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as s ice, and due to	stated. the cause(s)
	Vithi Com	Ž	29b. Signature and title of certifier				29c. License				gned (Month,	
	and a second		Word I	5	un, pl	1	RES	5-000		Nove	nla 16	2009
				MD PhD	4940		int) ika Av	erve l	Buttimore	, Mc	yland	21224
	Star Registra		31. Date filed (Month, Day, Year) NOV 2 0 2009	32. Registra	r's Signature	are	7			e t		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician ovenbur 15 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt 218 Itimore toga If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 □ M 2 🕶 F 213-20-1209 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County Department of Health and Mental Hygiene. Important; if item 22 a or 28a4 show important; if item 27 is marked other than "natural", or items 23a or 28a4 show important; if item 27 is marked other than "natural", or items is notified at once. 1 TVes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □₩6 Specify þ Specify: 3 Nidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Max 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 002 alto. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State National Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Li Heights 140 21267 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause peach line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 9 mor Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Doe to for as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g898 12-18-09 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:50^{p.м} George Washington Smith 2009 /Medical 11 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner n/a Joseph Richey Balto 8. Date of Birth (Month, Day, Year) 2-22-1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1**∑** M 2□ F Hours Min. 212-20-5577 Director MD 82 Usual Residence of Decedent 10a, State 10b. County show 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at n/a Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 W. Franklin Street apt502 21201 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2X No Black Specify: ð Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)n/a Elementary/Secondary (0-12) Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Parker John Wesley Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i and 2 Health 2630 Kirk Avenue Jessica L. Hunter-Niece Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ₹ permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet 11-23-09 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H lade Wan 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or comilications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the cause of the death. Approximate Interval Between set and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical aftending philor are the Box IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the a 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy this certificate Vital 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2/10/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Certification: To 6 hother (Specif 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 atural neral Director: A filled in by the fr 1 □Yes 2 □No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral [29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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32. Reg

Registrar

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#7 Perfft, 6897, 11/24/09, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, ^{Da}2009 NOV. 10:45 P M Doris C. Shryock 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Ridgeway Manor Nursing Home
5. Social Security Number | 6. Sex | 7. Aç Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2**X** F Months Days Hours Min. 92 May 12, Maryland 577-03-4005 10c. City. Town or Location 10b. County 10d. Inside City Limits Baltimore Catonsville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 190 Cherrydell Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola George Atkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 S. Rolling Road Catonsville MD 21228 John Shryock Jr. -son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11-19-2009 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part1. Entering disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Capacitize Heart Failure Approximate Interval Between Onset and Death
I Month Congestive Heart Failure Due to (or as a consequence of) Aortic Stenosis 1 Year Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 D No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Division of Vital Records, To the Hospital or Attending Physician:

physician and s the burial-trans

attending p

signed by the at be detached f

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death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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page ; certificate

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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/Medical

10a. State

MD

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Clostridium Difficily Colitis Completed 25. Was case referred to medical examiner? Be 1 Tes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of ce

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pine heights 1001

32. Registrar's Signature

29c. License number

D24781

29d. Date signed (Month, Day, Year)

11/16/09

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia House Lorien Nursing and Rebab Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1√2 M 2 □ F Months Days Hours Min 84 Director 113-14-5845 Dec. 26, 1924 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐Yes 2 ☐ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6334 Cedar Lane 21044 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Industrial Engineer Aviation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Frank Martin Skillman Olive May Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4045 Chariots Flight Way, Ellicott City, Maryland 21042 <u> Richard Davis/Nephew</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 18. 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 2009 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip... Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 06 Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other sig in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 No 3 | Probably 4 | Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 1∐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes 2 ER/Outpatient 3 DOA ပ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 🔲 Yes 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month Day, Year)

State Registrar 31. Date filled (Month, Day, Year)

NOV 20

eath (Item/23a).(Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Jane Shroyer Month Year Medical Vovember 9:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore City 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth (Month, Day, Yes Oct. 31. 9. Birthplace (State or Foreign 214-38-2945 1 - M 2 - TF Months Days Hours Director Maryland 69 1940 Usual Residence of Decedent 28a-f shov 10h. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Baltimore 1X Yes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3838 Roland Avenue 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Let \mathcal{L} $\mathcal{L}\in\mathcal{L}$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 □ Divorced If Yes, Give Completed Specify: White Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Merson Dorothy Marie Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Jones/Daughter 21 Powderock Place, Nottingham, MD 21236 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith 11/18/09 Rosechle, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel, & Cremation Services tools 8800 Harford Rd. Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Loca Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury MOONE Examine the attending physician and thed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) that initiated events resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Pregnant ☐ ☐ Unknown Pregnant at time of death Month detached signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed No 1 ☐ Yes 2 ☐ No ☐ Yes director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 25 s after death.

I Director: After this contained alignment of the contained Certificate: To 1 Nnpatient 2 Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work ☐ Accident
☐ Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d, Date signed (Month, Day, Year) 438946 MD November, 13 me and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Leone

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# SperFH, G899, 1/5/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Harvey Thompson 9:30PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Mumber If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 1 3 M 2 1 F Hours Country) Maryland 78 Director 214-30-1931 August 1931 Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD St. Mary's 1 Yes 2 No Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20991 Thomas Carter Lane 20609 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
I is marked other than "natural", or iter 11. Marital Status 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 Married 1 対 Yes 2 □ No If Yes, Give 1952 - Year or Dates. 1955 Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 12 Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen L. Thompson Mary E. Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i PO Box 187, Clements, MD permit. Page 1 and 2 Department of Healt Important: If item 2 Linda D. Gough/Daughter 20624 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/18/09 Metropolitan Crematory Alexandria, 21. Signature of Funeral Service Licensee Neptune Society, 34042 22. Name and Address of Facility any US Hwy 19 N, Palm Harbor, Florida enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest represents failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ HYPERMABIL RESPIRATORY Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner use as the burial-transi INTERSTITIAL LUNG DISEASE that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 2 🗌 No 3 Probably 4 Unknown 1 Yes certificate has been 24a. Was an 24b. Were autopsy findings available autopsv prior to completion of cause of death? performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 1 No ျပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural (Month, Day, Year) 5 Pending work' within 24 hours after death To the Funeral Director: / Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 69683 109 realin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Mary's Hospital Leonardtown, MD MALINI g2. Registrar's Signature 31. Date filed (Month, Day, State arko Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Lester Winton Turner 2009 14, 2:45 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 106 Plumtree Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days North Carolina Hours Min 1 X M 2 ☐ F Yrs 242-16**-**1673 89 May 14, 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Plumtree Road 21015 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister Religion 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Andrew Turner Virginia (nmn) Day 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Arnold / Daughter 801 Edgewood Road, Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State T∰Burial 2 ☐ Cremation 3 ☐ Removal from State Air Mem. Gardens 11/18/09 Bel Air, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final MALICNANT MELLANDMA 9 MONITYS disease or condition resulting in death) Due to (or as a consequence of): HPEN PONSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). HPON LIPIDEMIA Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 3 Ectopic pregnancy ath Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? ng in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, It a Prafical Examination that condition at any once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria

Examiner Physician/Medical cate has been signed by the page 2 should be detached Completed by filled in by the funeral director, Be Medical Certification: To 27

certificate

24 hours after death.

Funeral Director: After this

within 2 To the

3b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown
art II. Other significant condition	ns contributing to death but not resulting

examiner?								
1 Yes 2 1 1	lo	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 🛭	OOA Other: 4 [☐ Nursing Ho	ome 5 🔀 Residence	6 □Other (Specify)
. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	1	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes		28d. Describe how inju	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - building, etc. (St	At home, farm, street	t, facto	ry, office		28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGOMY 001maar m 2227 OLD EMMORTON RD SUITE 220

State Registrar 31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2000 A **Physician** Madalene 404 Utermahlen Η. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Middleburg Carroll Brookfield Manor Resident Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □ M 2 🙀 F 87 Maryland Director March 7,1922 215-14-1948 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 X No Director Middleburg MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any Injury or other traumatic event once. U.S.A. 5800 Middleburg Rd. 21757 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) seamstress clothing factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther S. Utermahlen Cecelia Engleman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric K. Utermahlen/nephew 535 Locust Ave. Westminster, MD 21157 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/18/2009 | Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) AllCounty Cremation 21. Signature A neral Service Licent 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final al 12ars **Physician** when disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to firm, old cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 💆 No Day Pregnant at time of death 5 ☐ Other (specify) g | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) LIVEWO Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

requires that the death certificate be executed Box 68760. P.O. I Records. The law Division of Vital or Attending Physiclan:

Hospital

the Maryland

show

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the the algorithms in must be mailfad at

physician and s the burial-trans attending polyton for use as use as cate has been signed by the page 2 should be detached certificate has funeral director, After this within 24 hours after death. To the Funeral Director: A filled in by the

State Registrar

соmpletely

Medical

29b. Signature and title of certifier

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1201

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2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed

4 ☐ Homicide

(Check only

29a. Certifier

1 - For State Registrar 1. Decedent's

Director

Funeral

Be Completed by

2

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 2 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Physician

/Medical

Examiner

Funeral

Director

	Please	Type or									•	le.	
For State Registrar		State o	f Marylar		epartme C <i>ertifica</i>			па М		_			0 7
Registrar 1. Decedent's Name	e (First, Middle, I	ast)			. UI UIIU d	01	Julii		2. Date of De		200	9	3Tine 2De th
Barbara Varner Month 10 16 Zoug 350 PM										350 CM			
4a. Facility Name (/	f not institution, g	ive street and nu		1 1	4b. City	y, Town,	or Location of	Death	> ,	40	. County of		'
Univers	11-1	ecialh	Hosp		1		- more		·M				
5. Social Security N 202-26-5		Sex 1 □ M 2KDKF	7. Age (In yrs.		Months	er 1 Yea s Day:		Min.	8. Date of Bird (Month, Da	y, Year)	9. Birthpl Coun	
Usual Residence of				74 ''					March 2	8, I	935		PA
10a. State	10b. County		10c. Ci	ty, Town o	r Location							1	0d. Inside City Limits
MD	Prince	George	Lau	rel									1X Yes 2 No
10e. Street and Nu					10f. Zip Code 10g. Citizen of What C						at Coun	try?	
	rroll Av		4-4-	10		0707		-0.40	-16.34	US		Amed	an Indian
11. Marital Status	ind OM Marria	Armed F		J.S.	13. Was Dec If Yes, sp	edent of pecify Cu	f Hispanic Origi uban, Mexican,	in? (Spe Puerto	ecity Yes or No Rican, etc.)	-	14. Race - Black,	White,	etc.
1 ☐ Never Marr 3 ☐ Widowed	ied 2⊠ Married 4 Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes	2 🖾 N	o Specify:				Specify:	whi	.te
	15. Decedent's	Education			ecedent's Us			of world	ina	16b. F	Kind of Busi	ness/Inc	dustry
Elementary/Seco	oify only highest g andary (0-12)	rade completed) College (1-4or 5+)	- ' <i>'</i>	ife. DO NOT	use retii		ui workii	ng			•	
12				Offi	ce Mar	nage	1				edica		
17. Father's Name									(First, Middle,		n Surname))	
	d Riddil			101 1	Apilia - A 1 1	00 /01-			Auberl		0. Ta	toto 7:	Code
19a. Informant's N			and			•	et and Number					iate, Zip	Code)
Charles 20a. Method of Dis		ri/ nuspa		Place of D	Disposition (N	ame of	Ave., I		Date		ocation - C	ity or To	wn, State
1 ☐ Burial 2 4 ☐ Donation	☑ Cremation 3 5 ☐ Other (Spec	cify)	Stato	cemetery,	ciematory or rundel	cre Cre	m.	Nov. 20	. 19 , 009	0	dento	n, M	ID
21. Signature of Fi	C1/ //	ensee	M010	53			ress of Facility						P.A.
23a. Part1. Enter t	the disease, or co	mplications that	caused the dea								2070		Approximate
shock, or hea Immediate Cause	art failure. List on (Final	ly one cause on	each line.										Interval Between Onset and Death
disease or condition resulting in death)		а.	(or as a conse	quence of	lence of):								20045
		. Ve	11 (tor - Associated Promone								3 don't	
Sequentially list co if any, leading to in cause. Enter Under	onditions, nmediate	D	(or as a conse	quence of									
Cause (Disease or that initiated events	injury s	0.	· Respirating Failure									10 months	
resulting in death)	LdSI		(or as a conse	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								1	
		Ld	entr-1	C	or d	24	ndim	~ e					Lyear
IF FEMALE: 23b. Was deceden in the past 12		1 ☐ Live	itcome pf pregr	al death	3 □Ectopic						23d. Date Mont		ery Day Year
1 ☐ Yes 2 9 ☐ Unknown	M.No	4∐Preg 9□Unkr	nant at time of nown	death	5 Other ((specify)							
Part II. Other signi		contributing to d	leath but not re	sulting in t	he underlying	j cause (given in Part I.		23e. Did 1	tobacco	use contrib	oute to th	ne cause of death?
Cono	restive	Henr	+ F	24.10	~~e				1 🗆	Yes :	2 X No 3	B ☐ Prob	oably 4 □Unknown
Dec. la Mar VI cant - Secondary 24a. Was an 24b. Were autopsy findings available								psv findings available					
· vec.	-w./w/	0 (2)	~ (~()	um			_	auto		pri de	ior to con eath? Yes	mpletion of cause of
25. Was case reference	rred to medical							of Death	(Check only	-,-			
1 □ Yes 2	·		inpatient 2	7		JUA			me 5□Resi				y)
27. Manner of Dea 1 Natural 2 Accident	th 5 □ Pending investigati	'	of Injury ofth, Day Year)	28b. Tir Inj	me of ury M	28c. In W	njuryat √ork? □Yes 2□N		28d. Describe	how inj	ury occurre	d	
3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	20e, Flac	e of injury - At I ling, etc. <i>(Sp</i> ec	nome, farn	n, street, facto	ory, offic	ce		28f. Location (City or To			r or Rura	al Route Number,
29a. Certifier (Check only one)	1 Certifying I	Physiclan: To the aminer: On the	e best of my kr	owledge, ation and/	death occurre or investigati	ed at the	e time, date and y opinion, deat	d place, th occur	and due to the red at the time	cause(s) and man nd place, ar	ner as s	stated. o the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

> State Registrar

DHMH 17 Rev 1/2001

MI

601

29c. License number

D0061882

29d. Date signed (Month, Day, Year)

11-18-2009

South Charles St Baltimore MD

71230

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2116 M NOVEMBER 16 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Caltimore Baltimore City ltimore If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Fort Social Security Number 7. Age (In vrs. last birthday) Date of Birth <u>(Month, Day,</u> **Funeral** Year North Carolina 213-60-345 1 M 2 N Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f shorthe Madical Examiner in ust be notified at MD 1 Yes 2 No Director mou 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21214 usa by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ 100 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 █ No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) omesti tomemaker and Mental Hygi is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Department of Health a Important: If Item 27 is any injury or other trainonce. Ashle Batto ND 21234 Burnwood Sabelle daughter 1667 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Termation 3 ☐ Removal from State Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 14600 Liberty Balto MD 21207 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final -Physician 30 minutes disease or condition resulting in death) /Medical Examiner 30 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pr</u>egnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been s Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed After this certificate 24 No of Vital 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 12 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) mame and address of person who completed cause of death (Item 23a) (Type, Print Kees ttinor 240

DHMH 17 Rev 1/2001

State Registrar

nichard 31. Date filed (Month, Day,

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death th Year Day **Physician** MOYEMBER 18, 2009 JATKINS Y Town, or Location of Death
Randal Stown

Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Month, Day, Year) | 9 (Mont /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner rospita saltimore 5. Social Security Number If Under 1 Year | If Under 24 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Months -38-1123 1 □ M 2 □ Director Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Pedical Examiner must be conflict anone. Mills 1 Nes 2 No Funeral Director 20 Himae Windsor 10e. Street and Number 10g. Citizen of What Country? 2124 Lane SA14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ₩ Specify. Completed by Black Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) borer ractor Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Circle Battimore, .-daughter Edgecomb MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Deremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licura 4600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORDINARY MARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Dav 5 Other (specify) Division of Vital Records, P.O. 9 Unknow Part H. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL 24a. Was an certificate has autopsy perform 1 ☐Yes 21 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified mella 00041410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINGER P 2405P17B1 RANDAUSTOWN MORTHYNEST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State of I	viaryiar		artment of F tificate of L		vientai Hy	giene Reg. No	2009	37281	
	Physicia		Decedent's Name (First, I Verdan		^{t)} edel					2. Date of De. Month November		200 ^y ear	3. Time of Death 8:30 P. M	
	Medic Examin		4a. Facility Name (if not inst.)			Location of Death	'		. County of Death		
	Funeral		10646 Hickory (5. Social Security Number	Crest L		Age (In vrs.	last birthday)	If Under 1 Year	mbia I If Under 24 Hrs.	8. Date of Bir	th	Howard 9. Birtl	hplace (State or Foreign	
	Director		506-20-7049 Usual Residence of Decede	1.7	™ M 2 □ F		35 Yrs.	Months Days	Hours Min.	June 25,		4 Cou	rntry) Kansas	
	land show dat	tor	10a. State 10b. C			10c. Ci	ty, Town or Lo						10d. Inside City Limits	
	e Mary 28a-1 notifie)irec		loward			Co1	umbia					1 Yes 2 No	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at,	Funeral Director	10e. Street and Number 10646 Hickory (rest L	ane			10f. Zip Code 21044				10g. Citizen of What Country? U.S.A.		
10	r death or items iner m		11. Marital Status	Married	12. Was Deceder Armed Force	2	S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)		14. Race - Amer Black, White		
3036	urs afte ural", c	Completed by	3 Widowed 4 Div		1 Yes 2 If Yes, Give Year or Dates	For	rce 1	Yes 2 🔼 No	Specify:			Specify: Wh	ite	
15-(72 hou n "nat Aedica	nple	(Specify only		de completed)		[(Give i	lent's Usual Occup kind of work done o O NOT use retired)	during most of wor	king	16b. H	(ind of Business I	ndustry	
212	ifiled within 72 hour tal Hygiene. of other than "natul event, the Medical		Elementary/Seconday (0	-12)	College (1-4 o	or 5+)		Employed			Gı	raphic Art	S	
land	should be filed within 7: and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Mic Joseph F. Wi.e						18. Mother's Nan Agnes C.	ne (First, Middle, Sponse1	Maiden	Surname)		
Maryland 21215-0036	permit. Page 1 and 2 should be for Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Rela		pe, Print) Wife)			ng Address (Street a					· ·	
Baltimore,	ge 1 and t of Heal If item or other		20a. Method of Disposition	ation 3	Removal from Sta	ite (Place of Dispo cemetery, cren	sition (Name of natory or other place	ce)	Date	20c. L	ocation - City or	Town, State	
altim	nit. Pag artmen oortant: injury		4 ☐ Donation 5 ☐ O 21. Signature of Funeral Se	ther (Specif	0	St.		hurch Cene			Cla	rksville,	Maryland	
Ä	Imp Per Imp any		1 Mulife				5	Name and Address Jitzke Fune 1555 Twin K	Nolls Road	Columbi		aryland 21	045	
	(Nimbelsis)		23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final	se, or comp List only or	olications that cause on each	ine.		TOSTAT			rest,		Approximate Interval Between Qnset and Death	
•	Medical Examiner		disease or condition resulting in death)	-	a. Due to (or a	as a conseq		ILOSIMI	e and	ハレ			Hece	
	Examiner	Į.	Sequentially list conditions		b. Die to ford	ie a conesq	Berne di							
12	uted did	amin	cause. Enter Underlying Cause (Disease or iinjury that initiated events	1	c		301100 317.							
5	ath certificate be executed attending physician and for use as the burial-transit	edical Examiner	resulting in death) Last	L	Due to (or a	is a conseq	uence of):							
3760	ificate ig phys as the		IF FEMALE:	_	d									
Box 68	death certifi ne attending ed for use a	cian/I	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?		23c. If yes, outcon 1 ☐ Live Birt 4 ☐ Pregnan	h 2 🗆 Fet	aldeath 3	Ectopic pregnand Other (specify)	ey			23d. Date of deli	very Day Year	
	de e	hysic	1 Yes 2 No 9 Unknown		9 Unknow		dealii 3 L	Other (specify)						
s, P.O.	law requires that the de as been signed by the ? 2 should be detached	Completed by Physician/N	Part II. Other significant co	nditions co	ontributing to deat	n but not re	sulting in the u	nderlying cause giv	en in Part I.				the cause of death?	
ord	w requi	plete								24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of	
Rec	: The law cate has I									autor perfo 1 🏻 Yes	rmed?	death?	2 No	
/ital	rsician: The s certificate lirector, pag	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 5 No		Hospital:	ationt 2	ER/Outpatier	Oth	ace of Death (Checer:			Other (Specia	£ .\	
of	ding Physician: h. After this certific funeral director,	ate: T	27. Manner of Death	Pending	28a. Date of it		28b. Time of injury	28c. Injun	y at ?	28d. Describe			<u> </u>	
Division of Vital Records,	Attending Physician: The sr death. ector: After this certificate hby the funeral director, page	Certificate:	2 Accident II	nvestigation Could not be letermined	28e. Place of I			M 1 🗆	Yes 2 No	28f. Location (S	Street an	nd Number or Run	al Route Number,	
Div	oital or urs afte eral Dire	a Ce	8		a l	etc. (Specif				City or Tow				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: Al completed filled in by the fu	Medical	(Check 2 ☐ Med	lical Exami	ner: On the basis o	f examinatio	on and/or invest	occured at the time igation, in my opinion leath occurred at the	on, death occurred a	at the time, date a	and place	e, and due to the c	ause(s) and manner stated.	
	To with		29b. Signature and title of c	ertifier) . July	Kv	M>	29c. License	3850		29d. Da	ite signed (Month,	Day, Year)	
	15		30. Name and address of po	erson who c	ompleted cause o	f death (Iter	n 23a) (Type, F	rint) DC (olumbi	x MAn	1 Maria	210	44	
	Stat Registra	~ I	31. Date filed (Month, Day,)	ear)		strar's Signa	ature)			11000	~		
	•				A CONTRACTOR OF THE PERSON AND ADDRESS OF TH	1000	The state of the s							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9, 2009 7:05 AM /Medical Town, or Location of Death **Examiner** radlerock Way #1014 Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex . Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 7 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at olumbia 1 ☐ Yes 2 No Be Completed by Funeral Director CNtoward 10f. Zip Code 10g. Citizen of What Country? 21045 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 □Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Pages 1 and 2 should be filed went of Health and Mental Hyginant; If item 27 is marked other 's Name (First, Middle, Maiden Surname) ပ nformant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once. Niece 20b. Place of Disposition cemetery, crematory 2 Cremation 3 ☐ F on 5 ☐ Other (Specify) 1 🔲 Burial 3 Removal from State 4 Donation 21. Sign to e of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bream Immediate Cause (Final disease or condition resulting in death) **Physician** lyear) /Medical Due to (or as a consequence of): Examiner Anemio Squantally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □Yes 2 •No Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely

(Check only one)

oung 31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Knoll

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

North Dr. 5.140 Columbia MD

29d. Date signed (Month, Day, Year)

Nov, 20, 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 11, 2009 **Physician** 7:05 PM Katherine Hayman Wise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Health & Rehab Center Howard Ellicott City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 4, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number Funeral 212-07-9298 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it whether Event is a continued a once. 1 ☐ Yes 2XX No Director Maryland | Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 103 Overcrest Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 X No Specify: Specify: þ white 3 M Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) medical secretary medica1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertie Heyn Roger Hayman ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wise/son 10252 Bristol Channel Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory Nov. 13,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 2 21. Signature of Funeral Service Licensee 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alhero Scleroke (Circles vantilia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Pregnant at time of death 5 Other (specify) P.0. 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, چ ک 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after control to the Funeral Director: Aft 1_Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 730641

State Registrar Ramera

31. Date filed (Month, Day, Year)

0 1 9 2009 June 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabornally

32. Registrar's Signature

201-109

Back Rever meet Road Balkmer Maylend 1124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 9, 2009 **Physician** 2:45 P M Mary Lois Walls /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1618 Swallowcrest Road, Apt. E Harford Edgewood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours Months Days 1 □ M 2 X F Director 226-46-1470 29. 71 Virginia 1938 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. In the Maryland int: If item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiniar may be notified at any or other traumatic event, the Medical Examiniar may be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1618 Swallowcrest Rd. Apt. E 21040 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MiNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 💆 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Lee Walls ပ Nellie Rosetta Blevins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 Clayton Rd., Joppa, MD 21085 Nannie Lucille Russell / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Offiner (Specify) Hilltop Service Corp.: 11-13-09 Towson, Maryland 21. Sign up of Funeral 22. Name and Address of Facility
McComas Funeral Home, P.A 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** THEROSCLEROSIS ORONARY /Medical Due to (or as a consequence of) Examiner OMNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial branch SMOKI Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 ZNo 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) 59/984hya manuan

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

09-Jos

o8859 Sue Antonio Ze	-	0 00 16 16 00 00 00 00 00 00 00 00 00 00 00 00 00
Dhypinia	F	Registrar 2. Date of Death 3. Time of Death
Physicia edical Examir		Josue Antonio Zelava November 15, 2009 0415 hrs
1		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Death Baltimore
Funeral Director		5. Social Security Number / a 1 X M 2 F 18 Yrs. 1 Social Security Number 1 A 1 X M 2 F 18 Yrs. 1 Social Security Number 2 A 1 X M 2 F 18 Yrs. 1 Social Security Number 2 A 1 X M 2 F 18 Yrs. 1 Social Security Number 2 A 1 X M 2 F 18 Yrs. 1 Social Security Number 2 A 1 X Months 1 Year 1 If Under 1 Year 1 If Under 2 4 Hrs. 1 Social Social Security Min. 1 A 2 F 1 A 3 Country 1 A 3 C
Baltimore, MD 21215-0036 gernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If tiems 77 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County n/a 10c. City, Town or Location Baltimore 10d. Inside City Limits 1
Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau		20a. Method of Cisposition 1 X Burial 2 Cremation 3 Removal from State 4 Conation 5 Other Specify: 21. Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) Amor Eterno 21. Name and Address of Facility 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202
Physician	9 9	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Torso
executed ian and ial - transit	I Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate chief. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
Box 68760, e death certificate be exect the attending physician and for use as the burial - it	Physician/Medical	UNPENDED AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No 9 Unknown Day Year Day 1 Ves 2 No 9 Unknown Day Pregnant at time of death 5 Other (Specify) 9 Unknown Day 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be for the Hongrital for After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Completed by P	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1
Sion of Vital Rec Attending Physician: The r death. ector: After this certificate! by the fineral director, page	To Be	25. Was case referred to medical examiner? 1 Ves 2 No 1 No logarith Day Year) Notural 5 Pending 1 Pending
Divisio Spital or Atter hours after deat nneral Director y filled in by th	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse 28e. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide (Specify) Townhouse / Rowhouse 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) 114 Page Street Relitimers MD 21301
Ş	tate	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. 18^{Day}2009^{Year} Physician/ John G. Zeller Jr. 7:25p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 1 🔀 M 2 🗆 F Days 212-46-7484 Months Hours Min. $\operatorname{\mathtt{Dec}}_{\bullet}^{(Month,Day)}$ 62 1946 **Director** MD Usual Residence of Decedent · 28a-f show 10a. State 10c, City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits hours after death with the Maryland Director MD Baltimore Essex 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 934 Mace Avenue Funeral 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. <u></u> 1 Never Married 2 Married Baltimóre, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Line Handler MD Line Handler Co. 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John G. Zeller Sr. Dorothea Hoyt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dottie Humes /sister 934 Mace Avenue Baltimore MD 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 11/20/09 Baltimore MD 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licensee <u>Connelly Funeral Home of Essex</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition CAS Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-trans Due to (or as a consequence of) attending physician for use as the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 2 No Division of Vital Records, P.Ó. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. tate has been signed page 2 should be dea 23e. Did tobacco use contribute to the cause of death? δ 2 XNo 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.
To the Funeral Director. After this certificate has E completed filled in by the funeral director, page 2 si autopsy performe 1 🗌 Yes 2 🗀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ပ္ nospice 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending work' 1 ☐ Yes 2 ☐ No М Investigation Accident 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/23/2009 Medical Anthony Miranda Acostar 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1215 Tyler Avenue Annapolis If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours 8/25/1961 Country 1 X M 2 □ F Director 48 217-80-0025 Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 1215 Tyler Avenue 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Filipino 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Private Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Confesor Fechalin Miranda Atanacio Labrador Acostar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5891 Stephen Rd, Huntingtown MD 20639 Chris Acostar - Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Dremation 3 Removal from State Baltimore Crematory | 10/30/2009 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Miglin 147 Duke of Gloucester St. Annapolis. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOURSCHLAR Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-trans resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 2 🗌 No page 2 should be detached Unknown 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical examiner? Be funeral director. 26. Place of Death (Check only one) Hospital: Other: 2 No ျှ 1 🗆 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at fter death. Director After t Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours

To the Funeral C Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0831 10/27/2009 amous of person who completed cause of death (Item 23a) (Type, Print) Defen & Highway

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year,

32. Pégistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:49 DM Alderton November 2009 Julia Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 9 / 30 / 1 9 2 9 9. Birthplace (State or Foreign Country) Ireland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F 577-36-0151 80 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercitive reust be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 14631 Good Hope Road 20905 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) J Hygiene. Goddard Space Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainment. Flight Center Procurement Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Owen Patrick Long Susan Kelly ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14631 Good Hope Road, Silver Spring, Richard Pennoyer - Son 20905 MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/04/2009 Silver Spring, Maryland Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses ichele Vetula MO1241 |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Deep Venous Thrombosis Sequentially list conditions, if any, leading to infine diata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consecuence of Examiner Attending Physician: The law requires that the death certificate be executed Recent Hip Surgery Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed been Coronary Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate Atrial Fibrillation 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🛚 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death Funeral Director: / 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D D0068681 November 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Chary Maheshwary, 1500 Forect Glen Rd., Silver Spring, 31. Date filed (Month, Day, Year) State 04 Registrar

DHMH 17 Rev 1/2001

anne Ammons		rtment of Health and Mental F tificate of Death	Reg. No.	109 3728
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year November 7, 2009	3. Time of Death 1358 hrs
Z \	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	h 4c. County of De	
/ Funeral	904 Mallard Circle 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24Hr	Anne Arund s. 8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or Foreign
Director	212-19-4832 _{1 M 2 XF} 35	Yrs. Months Days Hours Mi	05/19/1974 N	Country) Naryland
w any		Town or Location		10d. Inside City Limits 1 Yes 2 X No
ryland a-f sho t once.	MD Anne Arundel Arr	10f. Zip Code	10g. Citizen of What C	
with the Maryland us 23a or 28a-f sho be notified at once.	904 Mallard Circle	21012	USA	
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medial Examiner must be notified at once Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puert	o Ricán, etc.) White, etc	nerican Indian, Black, c. White
urs after tural", miner	Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of	Specify: work done 16b. Kind of Busine	
5-0036 led within 72 hours after dygiene. other than "natural", the Mediral Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	during most of working life. DO NOT use re Lawyer	tired) Kaplan U	niv.
	17. Father's Name (First, Middle, Last) Richard P. Ammons		ne (First, Middle, Maiden Surname) K. Schatzman	
D 2121 should be fil and Mental F 7 is marked natic event, To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of		tate, Zip Code)
e, MD and 2 shot Health and item 27 is r traumatir	Richard P. Ammons / Father 20a. Method of Disposition 20b. F	904 Mallard Circle A		y or Town, State
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, To Be	1 Burial 2 X Cremation 3 Removal from State A	LIGHT Crematory,	ov. 11, 2009 Glen Bur	
Balti permit. Departi Import Injury	21. Signature of Experient Service Licensee	Barranco & Sons, 1 495 Gov. Ritchie	P.A. Severna Park Hwy, Severna Park	Funeral Home MD 21146
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Myocardial in	Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) Tryocatulat It			- Dodan
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	·):		
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last):		
60, ate be executed thysician and e burial - transit	X UNPENDED AMENDED	7.permE, g900 2/17/10	TT.	
8760 ifficate b ng physi ss the bu	IF FEMALE: 23c. If yes, outcome of pregr 23b. Was decedent pregnant in the	nancy 2 Fetal death 3 Ectopic preg	23d. Date of del	ivery Day Y ear
). Box 6876(the death certificate by the attending phy sched for use as the t	past 12 months? 1 Yes 2 No 9 Unknown			8
that the danced by the detached by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribut	
ords, P.C w requires that as been signed I should be deta		·	- 1	Probably 4 Unknown e autopsy findings available
Records, The law requires ficate has been sign, page 2 should be Completed		-	autopsy prior performed? deat	to completion of cause of
Vital Rec ysician: The I his certificate I director, page o Be Conr	25. Was case referred to medical	26.Place of Death (Chec		163 2 110
f Vita Physicia er this ce rral direc	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Other Nurs 28b. Time of Injury 28c. Injury at Work?	sing Home 5 Residence 6 C	Other: Scene
on o ending ath. or: Aft	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	25a. Doscinso non injury cocanica	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi ledical Certification: To Be Completed by Physician/Medical Ei	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At he (Specify)	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number of or Town, State)	or Rural Route Number, City
To the Hosp within 24 hos To the Fune completely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) Medical Examiner: On the basis of examination a	ge, death occurred at the time, date and place, a nd/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as	stated. to the cause(s)
To vit To con	and manner stated. 29b. Signature, and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	Mul J/M	O.C.M.E.	November 8,	2009
8_5	30. Name and address of person who mple a cause of death (Item Russell Alexander MD. Assistant Medical Exam		MD 21201	
State Registrar	I NAVITO ODDO I A	B. Sarked		
DHMH 17 Rev 1/2001	THE TOTAL STREET	ORIGINAL	CONTE	

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 11:00 p M November George Frederick Alban, Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 154 Bertie Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Min. 1**½** M 2□ F Days Hours MD Director 71 Nov 12 1937 219-36-0790 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Westminster Carroll MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with USA 21157 154 Bertie Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental HI Important: If item 27 Is marked oth any injury or other traumatic event Be Hattie Davis George Frederick Alban, Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1798 Ridge Road Westminster, MD Barbara Rodgers/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/06/2009 | Westminster, MD Kriders Church Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. ach 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer **Physician** 400V disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of gertifier odo 52435 Nou 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHACKS 291 Stonev HINU 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parker Registrar NOV 05

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Cegibles State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:00 October Charles Henry Blades 25 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **E**xaminer Washington Adventist Hospital Takoma Park er 1 Year | If Under 24 H Montgomer State or Foreign 8. Date of Birth Funeral (Month, Day, Year) 8/1/1930 1 🖳 M 2 🗆 F Months Davs Hours Min. Country) **Director** 217-26-2604 Maryland i and a survey. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Tracy's Landing Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20779 5885 Solomons Road within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 😾 Married 1 Yes 2 No If Yes, Give Completed by 55-57 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည be 1 Margaret Mitchell William Blades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5885 Solomons Rd, Tracy's Landing, MD 20779 Page 1 and 2 Frances Blades - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillcrest Mem. Gardens 10/29/09 Annapolis, MD 22. Name and Address of Facility 21, Signature of Funeral Service Licensee John M. Taylor Funeral Home Mydin T. Klobeit 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician erebro vasca disease or condition day Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi: Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) lor in the past 12 months? Pregnant at time of death Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗆 No 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes 욘 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 M Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, thin 24 hours after death.

the Funeral Director: After pleted filled in by the fun within 2 To the F DH 1041

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. M.D. 7901 Maple Ave., Takoma Park, MD 20912 David M. Brill

31. Date filed (Month, Day, Year NOV 02

(Check

only one) 29b. Signature and title of certifier

3 [

32. Registrar's Signature

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

October 26, 2009

D3660

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:00 PM Teresa Brady 2009 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Calvert Chesapeake Beach 2247 Ivy Lane If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Hours 1 □ M 2 🕱 F Washington, DO Director 1945 577-58-4760 63 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Anne Arundel Maryland Odenton 10f. Zip Code 10g. Citizen of What Country? Funeral 8725 Autumn Ridge Court 21113 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 XXIO within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Sherwin-Williams and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Wall Covering Dept. Customer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James H. Colliflower, Jr. Ruth Frances Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Shawn Brady/Son 8725 Autumn Ridge Court, Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Ž009 4 Donation 5 Other (Specify) Suitland, Maryland Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Onset and Death Immediate Cause (Final Physician/ Hepatic Failure disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Metastatic Endometrial Carcinoma 27 months Sequentially list conditions ie to for as a consequence of If any leading to immedicause. Enter Underlying and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 X No ed by the a 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy page death? this certificate 1 🗌 Yes 2 🗌 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Brother's 6X Other (Specify) Residence Hospital 1 Tes 2 😾 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D16801 November 2, 2009

Registrar

DHMH 17 Rev 7/2009

State

9103 Franklin Square Drive, Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. McGuire, MD

31. Date filed (Month, Day, Year)

		For State Registrar	State o	f Maryland	d / Depa <i>Cer</i>	rtment c	of Health a	ınd Me		giene? Reg. No.	2009	37293
Physicia	an	1. Decedent's Name (First, Middle, I		Ray.				2.	Date of Dea Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, g		mber)	~	4b. City, Tow	n, or Location of	f Death	LOYEN		County of Death	1
_xa	٠.	Cooper Senior As	st. Grou	up Hame		Colum				Ho	ward	
Funeral Director		5. Social Security Number 6. 217–26–4901	Sex 1MM 2□F	7. Age (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 You Months Da	ear If Under 2 ays Hours	Min.	Date of Birt (Month, Da 10/10/	y, Year)	9. Birth Cou MD	place (State or Foreign ntry)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is widted Evan in a must be notified at once.	Funeral Director	10e. Street and Number	George's		r, Town or Lo	10f. Zip Co					en of What Cou	10d. Inside City Limits 1 ☐ Yes 2 XNo ntry?
eath v	eral	915 5th Street	12 Was Dec	edent Ever in U.S	3 13 1	207	07 of Hispanic Orig	nin? (Specif		USA 1	4. Race - Amer	ican Indian.
rs after de l', or item	by Fun	 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 	Armed Fo	orces? 2 No ive	'	f Yes, specify	Cuban, Mexican,	Puerto Ric	can, etc.)		Black, White,	
nin 72 hou 8. In "natura Vedical E	Completed	15. Decedent's (Specify only highest s	Education		(Give	lent's Usual O kind of work di DO NOT use re	one during most	of working		16b. Kin	d of Business/Ir	ndustry
ad with ygiene er tha	Com	7	College (Custod	lian						nty Schools
uld be file Mental H Irked oth Itic even	To Be	 Father's Name (First, Middle, La John W. Bruce 	st)					r's Name (F el Cac	First, Middle, ger	Maiden S	Surname)	
2 sho and is ma rauma		19a. Informant's Name/Relationship					reet and Number				Town, State, Z.	ip Code)
1 and Health em 27		Wilbert Nicholso 20a. Method of Disposition	n - nepr		<u> </u>	sition (Name on natory or other	eet, Lau	reI,			ation - City or T	own, State
Pages ment of tant: If it jury or o		1X Burial 2 ☐ Cremation 3 4☐ Donation 5 ☐ Other (Spe		State	kins U	MC Cem	.]	11/7/0			nland,	MD
permit Depar Impor any in		21. Signatur of Funeral Service Lie	1 Lu	well			ddress of Facility Washingt					20850
Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on	anch line						rrest,		Approximate Interval Between Onset and Death
Medical Examiner ohysician and the purial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseque)	ience of):	Ha	er Fa	len	2			Yesu
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	itcome of pregnal birth 2 Fetal gnant at time of de nown	death 3	Ectopic preg				2	3d. Date of deli Month	very Day Year
uires that signed by Id be deta	by	Part II. Other significant condition	s contributing to	eath but not resu	_	nderlying caus	e given in Part I.			obacco us		the cause of death?
The law requence that has been age 2 shou	Completed											topsy findings available ompletion of cause of
strifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place	of Death (1 ∐Yes Check only o	-	1 100	2 0
ing Physic After this of uneral dire		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date (Mor	Inpatient 2	ER/Outpatier 28b. Time o Injury		Injury at Work?	28	e 5 Resi	_	ther (Spec	cify)
or Attencater death Director:	Certification: To	2 Accident investigal 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place	e of Injury - At ho ling, etc. (Specify	me, farm, str		1 □Yes 2 □N fice		f. Location (City or To			ral Route Number,
e Hospital 24 hours e Funeral etely filled	Medical Co	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the caminer: On the land mar	e best of my know basis of examinationer stated.	wledge, deat tion and/or in	h occurred at t vestigation, in	the time, date an my opinion, deat	nd place, an th occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the within To the Compl	Me	29b. Signature and title of certifier				_	icense number				e signed (Month	
4			-			D.	22850	6		Tova	enter 9	, Z009
1		30. Name and address person w		se of death (Item			. #104.	Colim			•	
Sta Registr							, ,,2021					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oct. **Physician** 2009 31, 2:15 A Jean H. Bragg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pittsville Wicomico <u>34887 Railroad Ave.</u> If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🗓 F 213-44-2239 **Director** 12/22/1943 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Everings must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√☐ No MD Pittsville Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21850 Funeral 7704 Gumboro Rd 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2□XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 ☑ No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing home 11 Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Louise Miles George Hickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Bragg (husband) 7704 Gumboro Rd. Pittsville, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Pittsville Cemetery 11/04/2009 Pitsville MD 4 ☐ Donation 5 ☐ Other (Specify) Fun Service Licensee 22. Name and Address of Facility The Burbage Funeral Home <u> 108 William St. Berlin, MD 21811</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer **Physician** 110 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, country to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of: as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant In the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2[25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 5 Residence (Stothe Paughter's lence 1 Yes 2 No Hospital: Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) buall State U 5 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Lois Elaine Bidinger October 0 2009 9:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🛶 F 74 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show MD Carrol1 Sykesville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Bethway Drive 21784 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ∐Yes 2 1 No If Yes, Give 1 Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Thomas Nona Keefer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph L. Bidinger (spouse) 32 Bethway Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State Lake View Memorial 11-4-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Duge Haight Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran law requires that the death certificate be exect Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No 1 🖂 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifiei 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the 29c. License number death (Item 23a) (Type, Print) 30. Name and address Manche 32. Registrar's Signature State Registrar

			For State Registrar	State of M	aryland / [Departmo Certific			and Me		jiene _{leg. No.} 2 (009	37298
	D		1. Decedent's Name (First, Middle, L	ast)					2.	Date of Dea	th Day	Year	3. Time of Death
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	Director		215-10-9180 Usual Residence of Decedent		103				1	eb 05	1906		MD
	ow ow		10a. State 10b. County		10c. City, Town	n or Location		****			-		0d. Inside City Limits
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p	illed I Hyg other	Be C	17. Father's Name (First, Middle, Las	st)			-	18. Mother	r's Name <i>(F</i>	irst, Middle,	Ma <i>ide</i> n <i>Sur</i> na	me)	
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ary	should land Men s marke		19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Addr	ess (Street	and Numbe	er or Rural F	Route Numbe	r, City or Towr	, State, Zij	o Code)
	1 and 2 Health tem 27 i		Virginia Clatche	y/Daughter		17 Sta			et Ba	altimo		2122	
ore	ges 1 If iter or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	☐ Removal from State	20b. Place of cemeter	f Disposition (ry, crematory	Name of or other plac	e)	Date	9	20c. Location	- City or To	own, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy nijury or other traumatic event, I'm Marical Ever it not instituted at once.		21. Signature of Funeral Service Signature	A)		412	Washii	ngton	Road	West	napel, minster		21157
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P.O. I	w requires that the de been signed by the a should be detached for	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Pregnant a 9 ☐ Unknown	at time of death	5 Other	(specify) _						
S,	s that gned	by P	Part II. Other significant conditions		out not resulting in	n the underlyir	ng cause giv	en in Part I.		23e. Did to	bacco use cor	ntribute to	he cause of death?
ord	equire en si ould t	led I		NS10N						1 🗆 Y	es 2□No	3☐ Pro	bably 4 Unknown
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Ω	al or A after Dire d in b	Certification: To	4 ☐ Homicide determine	building, e	tc. (Specify)					City or To'w	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		Physician: To the best aminer: On the basis and manner si	of examination ar								
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	~[· //				Doo	5964	19		NO	101	2009
	MAN	•	30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type, Print)							
	4		marily and all and	. M. Bow), FA		5755 (Cedar	Lane	Columbi	la, M	21044
	Sta		31. Date filed (Month, Day, Year) $ \begin{array}{c} \text{NOV } 04 \end{array}$	32. Regist	rar's Signature	Back	الما						
	Registr	ar	NUV U 4	2003	10.	7							

Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Booth 2:00 a^M 3, 2009 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury 28068 Cross Creek Drive Wicomico If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 515-58-8709 Director 55 11/10/1953 California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Mudical Exar, and must be notified at Director Cape Coral 1 XYes 2 □ No Florida Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 SW 28th Street 33914 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No ģ Specify: Native American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Technological Innovation Elementary/Secondary (0-12) College (1-4or 5+) Management Enterprises owner/operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Peggy Nadine Rouse Russell Lee Booth Department of Health and Meni Important: If item 27 is marked any Injury or other traumatic e ္ရ 19a. Informant's Name/Relationship (Type. Print)
Amber K. Hebert/daughter Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 28068 Cross Creek Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 11/4/09 Salisbury Crematory 4 □ Donation 5 □ Other (Specify) Salisbury, MD ature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association avid # 501 Snow Hill Rd., Salisbury, MD 21804 (plompson) 23a. Part 1. Enter the disease, or commendations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 □ Yes 27 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ∐Yes 1 ☐ Yes > No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specifical Paughters 2 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cau e of ceath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State NOV 05 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 37298 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:41 MM 00 ALDI /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year 6. Sex. 1 M 2 □ F Number **Funeral** Min. Months Days Hours -26-2 -2140 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location "naturai", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No COMA Funeral Director 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: U Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ENTORCEMENT Department of Health and Mental Hygiene important: If fem 27 is marked other than any injury or other traumatic event, the Maonce. College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA BARNHART 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses emperanceville 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Ma P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) his certificate has been signed by the a director, page 2 should be detached to I Yes 2 □ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signatur

		•	For State Registrar		Sta	ate of Ma	arylan	•	artment of H <i>rtificate of L</i>		wental Hy	gien Reg. N	.20 0	9	3729	9
Ph	ysicia		1. Decedent's Nam	ne (First, Middle	, Last)						2. Date of De	ath	ay 20 ^Y E	ar	3. Time of Death	
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Fun Dire	eral ctor		5. Social Security N		6. Sex 1 ☐ M 2			ast birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date JAN • 2	rth ay, <i>Yeai</i> 23,1	943	Birthpl Count CON	ace (State or Foreig ry) NECTICUT	n 1
and	227		Usual Residence of	of Decedent 10b. County			10c. City	, Town or Lo	cation					10	d. Inside City Limits	3
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5-UU30 72 hours after death with the Maryland natural", or items 23a or 28a-f show	other traumatic event, the findical Ever it act must be notified at	þ	1 Never Mari		ied Ar	med Forces? ∐Yes 2 🛣 Yes, Give ear or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 □Yes 2XINo	Specify:	o Rican, etc.)		Black, V	Vhite, e	tc.	
D-C 72 hot 72 hot	dient	Completed	(Spe	15. Decedent	's Education at grade com	pleted)		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b.	Kind of Busin	ess/Ind	ustry	
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Dallimore, IN permit. Pages 1 and 2 Department of Health Important: If item 27 1	or othe		20a. Method of Dis					lace of Dispo emetery, crer	sition (Name of natory or other plac	e) NOVE	MBER	20c.	Location - Cit	y or To	wn, State	
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			23a. Part 1. Enter shock, or he	the disease, or art failure. List	complication	ns that caused use on each li	d the death	n. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	arrest,			Approximate Interval Between Onset and Death	
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DIVISION OF VITAL RECORDS, F.O. DOX 00/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ched for u	Physician/M	23b. Was deceder in the past 12 1 Yes 2 9 Unknow	2 months?	1 4	Live birth Pregnant a	2 Feta	I death 3	☐ Ectopic pregnanc ☐ Other (specify)	y			Month		Day Year	
S, R as that gned b	oe deta	by Pt	Part II. Other sign	ificant condition	ons contribut	ing to death b	out not resu	ulting in the u	nderlying cause give	en in Part I.					e cause of death?	
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To th withir To th	сошр	Me	29b. Signature and	d title of certifier	the				29c. Licens	e number)	29d. [Date signed (Month,	Day, Year)	
	e		30. Name and add	iress of person	who comple	ted cause of	death (Item	23a) (Type,	Print) DI	0),	MV	`	101		6	
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		-	_ State	artment of Health and M rtificate of Death	lental Hygiei	ne 2009	37300
			1. Decedent's Name (First, Middle, Last)	induce of Boats	O Data of Death		3. Time of Death
	Physicia Medic		JOHN EDWARD CRAWFORD SR		Month NOVEMBER	Day Year 12 200	9 6:50 P M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Funeral		FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	FREDERICK If Under 1 Year If Under 24 Hrs.	8. Date of Birth	FREDERI 9. Bir	thplace (State or Foreign
	Director		214-10-3563 1XI M 2 F 90 Yrs.	Months Days Hours Min.	10-3-191	(c)	ountry) MD
	nd at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	farylar 3a-f sl iffied	ecto	MD Frederick Frederic				1 🗆 Yes 2 🎦 No
	the N or 28	Ē	10e. Street and Number	10f, Zip Code	10g.	Citizen of What Co	ountry?
	h with ns 23a nust b	Funeral Director	54 South Pendleton Court	21703		USA	
	r deat or iten niner r	y Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
980	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by		1 ☐ Yes 2 🕱 No Specify:		Specify: Wh	ite
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Maryland 21215-0036	l and 2 should t f Health and Me tem 27 is mark other traumatic			ng Address (Street and Number or Rural ${\sf outh}\ {\sf Pendleton}\ {\sf Ct}$			
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_	Page 1 ment of ant: If it ury or o			natory or other place) ivet Cem. 11-17		•	Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility Kee 06 East Church Str			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent			, 11D	Approximate
P	hysician/		Immediate Cause (Final disease or condition	RENAL FA	ALLURE		Interval Between Onset and Death
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30	death certificate be executed ne attending physician and ed for use as the burial-transit	al E)	resulting in death) Last Due to (or as a consequence of):				
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989	eath certifica attending pl	M/ue	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 [Ectopic pregnancy		23d. Date of de	elivery
Division of Vital Records, P.O. Box 687	e death the atte hed for	Completed by Physician/Me		Other (specify)		Month	Day Year
<u>о</u> .	requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
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ion	tendin leath. tor: Af the fur	ifica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
ivis	l or Att after d Direct I in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St		ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the within 42 Hours after death. To the Funcial Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1	tigation, in my opinion, death occurred at	the time, date and pl	ace, and due to the	cause(s) and manner stated.
	o the	Š	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of ertifier	death occurred at the time, date and place 29c. License number		se(s) and manner as Date signed (Mont	
	-> - 0		I fall MD	500 61410			
	2		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) HOUSE - HY, 1			
	Stat Registra	te ar	31. Date filed (Month, Day Year) 32. Registrar's Signature 100 2009 (Linear St. Signature 100 2009)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 0 0 9 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 005 M 10 09 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 8606 Compass Court Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) Hours Days Min. 1 **X** M 2 □ F May 27, 85 1924 North Carolina 578-22-0242 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ▼ No Maryland Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8606 Compass Court 20708 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give 1942-45 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√No Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lonnie Cooper, Sr. Betty Maude Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gwendolyn F. Cooper/Wife 8606 Compass Court, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Fort Lincoln Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Uninsee 22. Name and Address of Facility
Francis J. Coll
500 University Funeral Home d. W., Silver lins Fi B**lv**d. Inc. Spring, MD 20901 Males Kehard Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a mseguence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) regnancy 23d. Date of delivery Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) e of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 25. Was case referred to medical

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

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7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinations to confined a

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 st Department of Heatth an Important: If item 27 is n any injury or other traur once.

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

Examine

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To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and compiletely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Physician/Medical Completed Certification: To

FEMALE: b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p
In the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tim

26. Place of Death (Check only one)

1 Yes 2 1 N	10	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	3 🔲 1	DOA Other: 4	I ☐ Nursing H	lome 5 Residence 6 □ Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined		nome, farm, street	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) Medical Examiner: On the basis of examination and/or investigued manner stated.		e, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL 31. Date filed (Month, Day, Year) NOV 05 2009

Registrar's Signature

APENTA

State Registrar

Medical

4415

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 37302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Reno Cox 2009 Medical Nov 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. Director 215-46-2434 95 6/3/1914 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Mikes Way 20736 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rollin Reno Nellie Loper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 Bentley Ct., Aiken, Gary Cox/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cem. Suitland, MD 11/9/09 4 Donation 5 Other (Specify) 22. Name and Address of Facility Raymond-Wood F . H., P . A. . Signature of Funeral Service Licensee PO Box 430, Dunkirk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (ardiovascular disense AtheroscienoHL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Justo for as a consequence on and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Yes signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Obstructive Records, Chronic Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementic 24a. Was an has performed? Hypothyroldism certificate 2 🗆 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D 50653 11-5-2009 GYAN C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dRW 5

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registra s Signature

Road Deale, m.D.

State of Maryland	State of Maryland / Department of Health and Mental Hygiene										
For State Registrar	Certificate of Death	Reg	J. No. 2	009	373						
1. Decedent's Name (First, Middle, Last)		2. Date of Death			3. Time of Dea						
William Francis Carter Sr.		November	Day 1	2009	12:03a						
As Escility Name (If not institution, give street and number)	4b. City. Town or Location of Death		4c Cou	inty of Death							

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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		Registrar						Ce	rtific	ate of	Death			Reg. N	40. Z	109	3/303
Physici /Medic		1. Decedent's Name William	, ,	,	Carter							2. Date of Domestin Novemb		^{Day} 1 2	2009	3. Time of Death 12:03a M	
Examin		4a. Facility Name (f	enour 1	Way E		Unit			Sy	kesvi	11e				tc. County Ca.1	rroll	
Funeral Director		5. Social Security N 218-28-0 Usual Residence of	549	6. Sex	M 2□F	7. Age (II	n yrs. la	st birthday) Yrs.	Mont	nder 1 Year ths Days	If Under Hours	Min.	8. Date of Bi (Month, D Oct 9	rth Pay, Yea 19	29	9. Birthpi Coun	lace (State or Foreign
works 1-t	tor	10a. State MD	10b. County					Town or Lo								10	0d. Inside City Limits 1 ☐ Yes 2 No
23a or 28a st be noti	Funeral Director	10e. Street and Nur 6516 Ride		Way E	East	Unit	3D			. Zip Code 21784				10g. (What Coun	try?
Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mail be notified at once.	þ	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		rried	2. Was Dec Armed Fo 1 1 Yes If Yes, Gi Year or D	rces? 2 No ve		. 13.°		ecedent of I specify Cub s 2 K No			ecify Yes or N Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: white		
giene. er than "natu! i he Medical	Completed	(Spec Elementary/Seco	dent's Usual Occupation kind of work done during most of working DO NOT use retired) puntant 16b. Kind of Busine financia						dustry								
Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Milton Cartor Mary Say												e, Maid	en Surnan	ne)	
lealth and m 27 Is ma her trauma		19a. Informant's Na William	F. Car					1442	Kiw	i Ct.	, Pun	ta G	al Route Num. orda, I	FL 3	3950		
tment of H tant: If ite jury or oth		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation		moval from	State	20b. Pla cei A11	ace of Dispo metery, crei Count	:у С	Cremat	ion	11-5		Sy	kesv	ille,	MD
Import any In		21. Signature of Fu	4 1			rert	_						ght Fur ille, N			me & (Chapel
ysician Medical		23a. Part 1. Enter the shock, or hea immediate Cause (disease or condition resulting in death)	rt failure. Lis (Final	r complica t only one	cause (n	aused the each line. (or as a co	91	1	U the I	mode of dy	ng, sụch a	s cardiac	or respiratory	est,	re-	1	Approximate Interval Between Onset and Death
ending physician and use as the burial-transit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, imediate rlying dinjury	b. c.		(or as a co											
physicia s the bur	n/Medical			d.					-								
y the attending iched for use a	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	230		birth 2 □ nant at tim	Fetal	death 3[oic pregnan r (specify) _	су					ate of delive	ery Day Year
en signed b ould be deta	þ	Part II. Other signif	ficant conditi	ions contr	ributing to d	eath but no	ot result	ting in the u	nderlyir	ng cause gi	ven in Part	1.	23e. Did		o use con		ne cause of death?
with ratious are upaut. To the Funeral Director: There this certificate has been signed by the after completely filled in by the funeral director, page 2 should be detached for a	Completed												24a. Wa: auto peri 1 □ Yes	opsy ormed			psy findings available impletion of cause of 2 No
certif	Be	25. Was case reference examiner?	red to medica	_	spital:					101		e of Deat	h (Check only	(bne)			
After this	on: To	1 Yes 2 ☐ 27. Manner of Death	h 5 □ Pendii	ng	1 ⊔ 28a. Date	<u> </u>	1	R/Outpatier 28b. Time o Injury	f	28c. Inju Wo	ry at	ursing Ho	ome 5 Res 28d. Describe			ner (Specify red	y)
Director:	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could detern		28e. Place build	of Injury	- At hon Specify)	ne, farm, str	M eet, fac]Yes 2□	INO	28f. Location City or To			ber or Rura	al Route Number,
ne Funera	edical C	29a. Certifier (Check only one)			er: On the b		aminati						and due to th red at the time				
To th	Me	29b. Signature and	title of certifie		5					29c licen	se number	31		29d. I	Date signe	wg (Month, 1	Day, Year)
3		30. Name and addr	Gaffa	who com	npleted caus	se of death	(Item	23a) (Type,	Print)	F 4	165/21	, WSt	3, Mi	121	1157		
Sta Registr		31. Date filed (Moni	th, Day Noar,	06	32. F	legistra's Den	Signatu	ire A.	1	arke	,						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 5:10 PM Robert Joseph Christian, Sr. 2009 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** USpice 9omico 7. Age (În yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₺ M 2 □ F Months Days 69 Director 217-36-1676 Feb. 26, 1940 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Mulcal Evananter must be netified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 No MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9234 Taylor Road 21875 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2xx Married 1 ☐ Yes 217 No Specify: ģ Specify 3 Widowed 4 Divorced white Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Standardbred Horse Trainer Horses 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ John Christian Margaret Hollowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Christian (Wife) 9234 Taylor Road 21875 Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Nov. 4, 2009 Delmar, Delaware 2. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licenses 13 East Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Delmar, DE Immediate Cause (Final disease or condition resulting in death) **Physician** RRLTOSIG MRTHSTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Directo (or as a consequence of) burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 AN 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3 ☐ No has autopsy 2 - No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 ₹ Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannes of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No **6** □ Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 ☐ Homicide | Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cituntin 31. Date filed (Month, Day, Year) NOV 05 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

		-	For State State Registrar	iviai yiaira	Cen	tificate of D	lealth and N Death		Reg. No.	2005	37305
	Physicia		1. Decedent's Name (First, Middle, Last) WILLIAM	M HARV	VEY	DETER		2. Date of De Month Novembe	Day	Year 2009	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number				Location of Death		4c. C	ounty of Deat	
			Frederick Memorial Hospi 5. Social Security Number 6. Sex 7.	Ltal Age (In yrs. last	t hirthday)	Freder	ick If Under 24 Hrs.	8, Date of Bir		rederio	ck thplace (State or Foreign
	Funeral Director		213-16-1530 1⊠м 2□ F	88	Yrs.	Months Days	Hours Min.	Feb. 12	y, Year) 1921	Mar	untry) yland
	land f show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Loc	cation					10d. Inside City Limits
	e Mary r 28a-	Direc	Maryland Frederick 10e. Street and Number	Fre	ederic	k 10f. Zip Code			10a Citiza	en of What Co	1 Yes 2 No
	with th	Funeral Director	990 Waterford Drive #215			21702			rog, Gilize	USA	
_	s filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show other than matural", ar items 23a or 28a-f show the Medical Examiner must be notified at		11. Marital Status 12. Was Deceder Armed Force: 1 ☒ Never Married 2 ☐ Married 1 ☒ Yes 2	s?	13. W	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Ame Black, White	
9500-612	rs after ıral", o I Exam	ed by	1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 If Yes, Give Year or Dates	s. WWII	1	☐ Yes 2 🔀 No	Specify:		Sp	pecify: W	nite
בי	72 hou n "natu Nedica	Completed	15. Decedent's Education (Specify only highest grade completed)	d of Business	Industry						
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 of the control of the cont	or 5+)		NOT use retired) keeper			Manu	ıfactur	ing
Maryland	oe filed intal Hy ced oth	To Be	17. Father's Name (First, Middle, Last) William Issac Deter				18. Mother's Nam	e (First, Middle, Metzge:		mame) chtel	
ary	should be file and Mental I 7 is marked or raumatic eve		19a. Informant's Name/Relationship (Type, Print)	T	19b. Mailin	ig Address (Street a					o Code)
	and 2 Health		William W. Houck/cousin 20a. Method of Disposition			ambel 0al		Millers Date		MD 2	
Baltimore,	Page 1 nent of ant: If it ary or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ate cen	netery, crem	natory or other plac	e) ;			•	, Maryland
Balt	permit. Page 1 a Department of H Important: If ite any injury or of		21. Signature of Funeral Service Utrensee			Name and Addres				n Stree	et 0 21773
			23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	used the death.						LIC, III	Approximate Interval Between
-	1			Pireti							Onset and Death
	Physician/					rem	- لاحرا فر				48 hours
	Medical Examiner		resulting in death) Due to (or the control of the	as a consequer		1 Cum	- 4001 4				La years.
	Medical Examiner	miner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying		nce of):	· Cum	- ((~) (
6	Medical Examiner	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequer	nce of):	· · · · · · · · · · · · · · · · · · ·	- ((A) \(\sigma\)				
6	Medical Examiner Ohysician and the prival-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequer as a consequer	nce of):	Lum	-4014				
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Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate: To Be Completed by Physician/M	Part II. Other significant conditions contributing to death 23c. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death 27. Manner of Death 1 Noter algorithms Note algorithms Note algorithms 28a. Date of (Month, other miner) 29a. Certifier 1 Certifying Physician: To the best only one) 3 Certifying Nurse Practioner: To composite the property of the basis only one) 3 Certifying Nurse Practioner: To composite the property of the pass of the p	as a consequer as a consequer as a consequer me of pregnance the 2 Fetal of the attime of deal where the best of my knowled of examination atthe best of my knowled to find the best of my knowled the best of my knowle	P/Outpatien Bb. Time of injury Age, death of and/or invest knowledge, decath of and/o	26. Plant 3 DOA Other (specify) 28c. Injury work 1 Deet, factory, office occurred at the time tigation, in my opinic death occurred at the Cocurred at the Coc	ren in Part I. ace of Death (Chec. ar: 4 Nursing Ho, rat ? Yes 2 No , date and place, ar nn, death occurred a e time, date and place and under	1	obacco use Yes 2 an psy prmed? 2 No dence 6 how injury of wrn, State) Street and If wrn, State) suse(s) and and place, a e cause(s) a 29d. Date	Month e contribute to No 3 P 24b. Were au prior to death? 1 Yes Other (Special Control of the Control of th	livery Day Year the cause of death? robably 4 Junknown topsy findings available completion of cause of s 2 \square No sify) ral Route Number, ated. cause(s) and manner stated. stated. h, Day, Year)

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	Physic		1. Decedent's Name (First, Middle, Last) TAMSA PAYL	Downie	4	-	Date of Death Month D	Pay Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or L			c. County of Death	
	Funeral		Howard County General H.C 5. Social Security Number 6. Sex	ospital 7. Äge (In yrs. last birthday)	Columbia If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea	Howard 9. Birthp	lace (State or Foreign
	Director		439-56-8011 1 XM 2□ F	70 Yrs.	World S Days		ec. 31, 1		siana
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Maryll	ţ	Maryland Anne Arundel	Jessup					1 XYes 2 □ No
	h the	Director	10e. Street and Number	Jessup	10f. Zip Code		10g. 0	Citizen of What Coun	try?
	th wit		2048 Orchard Ave.		20794			U.S.A.	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ent, the Medical Exprision must be mylffled a	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 ☑ Yes, Gi Year or E Year or E	2 □ No ve	Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 2 No	panic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, 6 Specify: Whi	etc.
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anc	t be fi	Be				·		sii Suinaine)	
Ž	ss 1 and 2 should be filed vof Health and Mental Hygin filem 27 is marked other rother traumatic event, It	우	James Paul Downey Sr. 19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street an	Opal Roge and Number or Rural in		y or Town, State, Zip	Code)
	and 2 sealth ar	8	Laura A. Downey		Orchard A				
ore,	ges 1 an at of Heal If item 2		20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of mator) Po∆0 Pjer place)	Dat	te 20c.	Location - City or To	wn, State
<u>ii</u>	Page ment ant: If ury o		1 → Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Meadowrio	dge Memoria	al 11/12	/2009 E1k	ridge, Ma	ryland
Baltimore,	permit. Pages Department of Important: If it any Injury or conce.		21. Signature of Funeral Service Licensee		2. Name and Address	Kes		Tuneral Ch	
	70 = 40 O		200 Part I Fater the disease or complications that		and the second s			town, Mar	yland 21742 Approximate
4	Physician		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on immediate Cause (Final disease or condition	each line.	ter the mode of dying,	, such as cardiac of	respiratory arrest,		Interval Between Onset and Death
Ę	/Medical Examiner			(or as a consequence of):				ì	9
	18	'n	Sequentially list conditions.	Sumona (or as a consequence of):					
198	ansit	Examiner	Cause (Disease or injury that initiated events						
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68760,	icate be executed physician and the burial-transit	edical	d						
Box 6	eath certifi attending I for use as	Physician/Mec	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive	ery Day Year
P.0	that the died by the detached	hys	9 ☐ Unknown 9 ☐ Unk	nown					
	es tha igned be dei	by P	Part II. Other significant conditions contributing to a Chroniz Ohchuek			in Part 1.		o use contribute to the	
ord	w requires to been signal should be	ted	Chroniz Ohennett	0.3	racy D	LE (VZG	1 🗆 Yes	2 No 3 Prot	pably 4 Unknown
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a	Ician: The certificate his ector, page		Diaphagnetez to	walysis			1 ☐ Yes 2	No 1 ☐ Yes	2 🗆 No
Σ	sicerti irecto	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/Outpatie	Othor	26. Place of Death (6 ☐ Other (Special	
of	ding Physici	n: To	27. Manner of Death 28a. Date	of Injury 28b. Time of	of 28c. Injury	at 28	Bd. Describe how in		<i>y</i> /
ion	death. ctor: After y the funer	atio	2 Accident investigation	nth, Day, Year) Injury	M 1 □ Ye	es 2□No			
Division of Vital Records,	al or Atte s after de I Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	e of Injury - At home, farm, st ling, etc. <i>(Specify)</i>	reet, factory, office	28	Bf. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the	ledical (29a. Certifier (Check only one) 1 CertIfying Physician: To the 2 Medical Examiner: On the and mar						
	To th withir To th	Me	29b. Signature and title of certifier	11/	29c. License	number	29d.	Date signed (Month,	Day, Year)
			Televert G. 4	Kut D	2 D18	457	N	04 09	,2009
	4+1		30. Name and address of person who completed cau	/ -	Print) 11055	LITT	CE ?	HELIXSK	, 2009 . T / Kuy
	1		31. Date filed (Month, Day, Year) 32. 1	Registrar's Signature	Cor	UMBI1	7, 111)	2104	4
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Registrar

State

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#26, perMD, 11/10/09, DPS, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29, 1:00 2009 Duffy Edward Bernard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Collingswood Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 002-03-6207 93 July 31 1916 New Hampshire Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 √ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20851 United States 100 First Street #343 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1944–65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Military Elementary/Secondary (0-12) College (1-4or 5+) Master Chief Petty Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lauzon Virginia Patrick Joseph Duffy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 100 First Street #343; Rockville, MD 20851 Kathleen Duffy / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/5/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Fundral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, of heart failure Immediate Ceure (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Seguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a detached t 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed | rector, page 2 should be det þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an was an autopsy performed?
Yes 2 No 10 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural ithin 24 hours after death.

the Funeral Director: After the fur М 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 茂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

To the F

complet 29d. Date signed (Month, Day, Year) DO062435 10/30/0 a) (Type, Print) Nate also Dr. Rockville, MD 20 29b. Signature and title of certifier 5 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMYAN SAYEN 1011 31. Date filed (Month, Day, Year) Registrar's Signature State 04 NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Oct o ber 3:45a.M 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOPKINS HUSPITA JOHAS 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA 5. Social Security Number **Funeral** Months 81 Director 205-22-4215 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be nuttiled at 1 ☐ Yes 2 ☐ No Director PA York Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral <u>68 Apache Pass</u> 17331 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 👿 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene.

Item 27 Is marked other than other traumatic event, the M Plumbing Supply Distributor 8 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry E. DeGroft Beulah B. Garrick ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jo Ann E. DeGroft Wife 68 Apache Pass, Hanover, PA 17331

of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If Ite
any injury or ot 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 11/2/09 Hanover, PA 17331 21. Signatur o Funeral Service Linensee 22. Name and Address of Facility PA 17340 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ttlestewn Approximate Interval Between Onset and Death Immediate Cause (Final Physician Luphred Andominal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence or) the Hospital or Attending Physlcian: The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No by the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No r this certifica ral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 RES-000 October 31,2009

chig

State Registrar 600 North Wolfe St, Baltimore, MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1Nh w21

Year)

31. Date filed (Month, Day,

MW.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:00a M Green Elseroad Shirlee LaRue November 4 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 1717 Emory Road
Social Security Number 6. Sex Reisterstown Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF 212-44-0264 66 **Director** 12/10/1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Reisterstown MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 items 23a 21136 U.S.A. 1717 Emory Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) music instruction piano teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LaRue Merryman Sterling Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 Is
any injury or other trau 17212 Grace Rd., Hampstead, Md. 21074 Daron Elseroad, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 11/5/2009 Hampstead, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Eline Funeral Home 934 South Main St., Hampstead, Md. 21074 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Renal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physlclan: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 1 ☐Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 Residence 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1/ Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sig

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 06

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

South Center St. Westminster MD 21157

		4	For State Registrar		State o	f Maryla		partment of H ertificate of D		ı Mental Hy	giene Reg. No	2009	37310	
	Physicia	n/	Decedent's Name	e (First, Middle	_					2. Date of De Month	eath Da		3. Time of Death 7:21 p M	
	Medic Examin	al .	4a. Facility Name (if	not institution,	give street and nun		ous Emai	4b. City, Town, or	Location of De	Novembe eath		2009 c. County of Death	7.21 P W	
	Examin	ζ.	13515	Colling	wood Terrac	e			ilver Sp			Montgo		
	Funeral Director		5. Social Security No. 227-32-72	63	6. Sex 1 ⊠ M 2 □ F		. last birthday, 17 Yrs.	If Under 1 Year Months Days	Months Days Hours Min. (Month, Da					
	show dat	tor	Usual Residence of 10a. State	Decedent 10b. County		10c. (City, Town or L	ocation				1	0d. Inside City Limits	
	Mary 28a-f	Director	Maryland		tgomery			Total Transport	Silver S	Spring			1 Yes 2 No	
	ith the 3a or t be r		10e. Street and Nun		1 W			10f. Zip Code	20904		10g. C	itizen of What Cour		
	ems 2	Funeral	11. Marital Status	Colling	12. Was Dece	dent Ever in t	U.S. 13	. Was Decedent of Hi	spanic Origin?	(Specify Yes or No	-	14. Race - Americ		
2	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The the and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	by	1 ☐ Never Marr		If Yes, Giv	2 🗌 No	-197/	If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		erto Rican, etc.)		Black, White, Specify: Afric	etc. an-American	
5	hours natura lical E	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine												
7	nin 72 ne. han " ı e Med	3 Widowed 4 Divorced Year or Dates. 1954-1974 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of working life. DO NOT use retired) 16c. Kind of Busine (Give kind of working life. DO NOT use retired) 16c. Kind of Busine (Give kin												
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d y	hould and M is mar		19a. informant's Na	ame/Relationsl	nip (Type, Print)		19b. Ma	iling Address (Street a	nd Number or	Rural Route Numb	er, City o	r Town, State, Zip (Code)	
ζ, Σ	and 2 s Health tem 27		Bernice E		Wife			5 Collingwood	Terrace					
_				☐ Cremation	3 🗷 Removal from	State	cemetery, cr	oosition (Name of ematory or other plac		Date		_ocation - City or To	,	
	4 Donation 5 Other (Specify) Arlington National Cemetery 11/20/2009 Arlington									lington, Vi				
21. Signature of Funeral Service Licenses 121. Signature of Funeral Service Licenses 122. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryla														
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pulmonary Sarcoidosis Pulmonary Sarcoidosis											
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	Examiner					•		Hypertension						
	س	iner	Sequentially list co it any, leading to in cause. Enter Unde	nmediate	D. —	(or as a cons		,,,						
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as,	equires een sig ould b		History	of Multi	ple Pulmona	ry Embo	li						bably 4 Unknown	
records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					•			per	opsy formed?	prior to co death?	psy findings available empletion of cause of	
<u> </u>	an: Th tificat tor, pa	BeC	25. Was case referr	red to medical				26. Pl	ace of Death (C	l 1 ∐ Yes Check only one)	2 🗷 1	No 1 Yes	2 L No	
VII	hysici his ce Il direc	은	examiner?					ient 3 DOA Othe	4 L Nursin	***		6 Other (Specifi	v)	
101	ling P .r After t funera	ate:	27. Manner of Deat 1 🗷 Natural	5 🗌 Pendir	19	of injury oth, Day, Year)	28b. Time injury	work		28d. Describe	how inju	iry occurred		
28d. Describe how injury occurred by the part of the p									I Route Number,					
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_	To with		29b. Signature and	title of certifie	7			29c. License	number	87	29d. D	ate signed (Month,	Day, Year)	
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			Interney	Medic	ine Clinic	- Wal	ter Re	ed AMC,	6900	Georgia	An	e, NW W	tated. Day, Year) L, 2009 Ashington DC	
	Sta Registr		31. Date filed (Mon	tn, Day, Year)	2009	Registrar's Sig	nature	ales		·			V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar MEND#29d+30perMD, 11/17/09, BW, MoCo Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) November 2009 Moshe Friedman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 12, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days 1 X M 2 □ F 128-44-7375 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20016 U.S.A. 4511 Yuma Street. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗓 No Specify. 3 Widowed 4 Divorced Caucasian 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Physicist Naval Research Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Azulau Isaac Friedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sarah Friedman - Wike 4511 Yuma St., NW. Washington, DC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 11/04/2009 Olney, Maryland 21. Signature of Funeral Service Lix nace 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Endocarditis Due to (or as a consequence of): Septicemia Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cardiac Arrest Due to (or as a consequence of): Left Foot Ulcer 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Tinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

/Medical Examiner Division of Vital Records, P.O. Box 68760, riedman, mashe Director: d in by the

Physician/Medical ģ Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Executer must a once.

Physician

Baltimore, Maryland 21215-0036

the Medical Execution must be notified at

Director

Funeral

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Completed

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with the Maryland

		24a. Was an autopsy performed? 1 □ Yes 2 図No 24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	ome 5 Residence 6 Other (Specify)								
27. Manner of Death 1 ⅓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred								
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								

1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 05 2009

M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1 - State Registrar #8, per f. home. 11/5/09, Certificate of Death E.T, WCHD Reg. No. 2009 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Jane E. Frederick /Medical 10/31/2009 5:42 Α 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Highway Ocean City
If Under 1 Year | If Under 24 Hrs. Plaza Hotel 9800 Coastal Worcester Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 184/1948 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 ₽ F Min. 61 Yrs Director PA 170-40-8136 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Michael Examiner must be notified at Director 1 ☐ Yes 2 ☐ No PA Lehigh <u>Allentown</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a Funeral 1025 Jefferson Avenue 18103 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 ∐Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ∐Yes 2K □ No Specify: White Specify è 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) teacher Parkland School Dist. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be ment of Health and Mental 27 is marked of traumatic even Jack Fink ၉ Ethel Sterner Fink 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Stephen W. Frederick (son) 1025 Jefferson Ave. Allentown PA 18103 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery 11/07/2009 Allentown PA 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year P.O. 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≥</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an Jas autopsy 2 ZNo 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specifyhote) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural ours after death.

neral Director: A
filled in by the fu death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 DSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours are To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

E.T &O State Registrar 20 Box1733

Name and address of person who completed cause of death, (Item 23a), (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Richard Eugene Fox 2009 12:42 p M November /Medical 4b. City, Town, or Location of Death
Westminster 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Carroll Hospice Dove House 8. Date of Birth (Month, Day, Year) Jun 26, 1950 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 59 Pennsylvania 217-54-9329 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c, City, Town or Location 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Modeal Examiner must be notified at 1 ☐Yes 2 No Westminster Carroll Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 630 Warfieldsburg Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No 1969 If Yes, Give Year or Dates: 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Completed by Specify: white 3 ☐ Widowed 4 🔀 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Mill 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Louise Hartsock William Oscar Fox, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Hoff, friend 630 Warfieldsburg Road, Westminster, MD 21157 20b. Place of Disposition (Name of Seamplery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Crematory 11/04/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licens 91 Willis Street, Westminster, MD 21157 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1∐Yes 2∐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐Yes 2 No 1 ☐Yes 2 No Hospital or Attending Physician: 1
 Hours after death.
 Funeral Director: After this certifica etely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NIF MOUSE 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Pure Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. To the within 2

31. Date filed (Month, Day, Year) State Registrar

29b. Signafure a

MOH IT

30. Name a

555 CENTER STREET, NARANG M.D

ress of person who completed cause of death (Item 23a) (Type, Print)



29c. License number D006.7468

29d. Date signed (Month, Day, Year)

11-04-2009

WESTMINSTER MARKLAND

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Franci	s Marie Fr	1	- For State	State	of Maryla	nd / Depa Ce	artment of rtificate of	Health Death	and	Menta	l Hygie	ne Reg.	No.	200	9 :	3731
	Physicia		tegistrar 1. Decedent's Name (Fi	rst, Middle,Las	t)							ate of Death	av Year		Time of De	1
Medi	cal Exami		Frances 1	Marie F	ritz							onth D ovember 1			0903 hr	S
			4a. Facility Name (if not			nber)	4	b. City, To		cation of I	Death		4c. County o			
			Frederick Mem	orial Hospi			Frederick Age (In vrs. last birthday) If Under 1 Year If Under 2				auto la r	Irs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or				
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	Director		212-50-74	56 1	M 2 XF	6	2 Yrs.				U	an 07	1947	Cour	itry) 1•11	
	8	_ h	Usual Residence of De	cedent . County		Inc. Cit	y, Town or Locati	on.							10d. Inside (City Limits
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	·land -f sho	흐	MD 10e. Street and Numbe	Carrol	.⊥		Wesaimic	10f. Zip (ode			100	. Citizen of Wh	nat Count	ry?	
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5	ath witems	Funeral	Never Married	2 Married	Armed Fo	rces?	If Y	es, specify	Cuban, I	Mexican, F	Puerto Rica	n, etc.)	White	e, etc.		
1	ter de		3	4 Divorced	1 Yes If Yes, Give Year	2 X No	1	Yes 2	X No	specify:			Specify:	Wh	ite_	
	urs af tural	Completed by	15. Decedent's Educa		Lor Dates:		16a. Deceden	t's Usual C	ccupatio	n (Give kir	nd of work	done	6b. Kind of Bu	isiness/In	dustry	
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Sr. Human Resources Assoc. Random Ho								use								
18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Esworthy								·)								
y 8 E 2 E B ELLESC OCINETIO								Zip Code)								
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;	timen ritmen ritant y or o		4 Donation 5 21. Signature of Funer	Other Specifical Service Lice	ńsee	Iv	leadow Br	amband.	Maren Maria	L of-Eρ¢ilityF	Tome a	and Ch	apel, E	2.A.		
	Depa Depa Impo		John K	12	1		41:	2 Was	hina	ton I	Road	Westm	inster,	, MD	2115	7
	Physician		23a. Part I. Enter the d	lisease, or com	plications that c	aused the dea	th. Do not enter t	he mode c	f dying, s	such as ca	rdiac or res	piratory arre	st, shock, or he	eart		ate Interval Onset and
1	'Medical		failure. List only of Immediate Cause (Fin	one cause on e lai disease a	acn line. L. Hynert	ensive	atheros	scler	otic	card	liovas	scular	diseas	3e	De	eath
	aminer		or condition resulting i	in death)	Due to (or as a	consequence	of):									
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		nine	if any, leading to imme cause. Enter Underly	ing Cause).	Consequence									ļ	
	E Sit	Examiner	(Disease or injury that events resulting in dea		Due to (or as a	consequence	e of):									
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	6 be e ysicial	ı w	IF FEMALE:			outcome of pr		LTIL	8070	1.2/			23d. Date of	of deliven	<u></u>	
	Records, P.O. Box 68760 The law requires that the death certificate licate has been signed by the attending physpage 2 should be detached for use as the bing to the street of the stre	sician/M	23b. Was decedent pre	egnant in the	1 Live I	birth	2 F	etal death	3	Ectopic	pregnancy		Month	Γ	Day	Year
	ox 6 th cer ttendi	Sicia	1 Yes 2 No	g 🕶 Hoknov	_ ' -	nant at time of	death 5 C	ther (Spe	cify)							
	Box ne death c the atten hed for us	Phys	Part II. Other signific		3 0111411		at resulting in the	underlying	cause o	iven in Pa	rt I.	23e. Did to	bacco use con	tribute to	the cause o	f death?
	i of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach tuneral director, page 2 should be detach.	ğ	Trafluor	an condition	N1) vir	al info	ection,	diabe	tes	me11	itus	1 Yes	2 No 3	3 Pro	bably 4 🗸	Unknown
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	cian: certif ector,	Be (25. Was case referred examiner?	d to medical	Hospital:	In-ations 0	✓ ER/Outpatier		OA	Other _A	Nursing F		Residence 6	Othe	er:	_
	of Vital Records, ng Physician: The law requin ther this certificate has been s meral director, page 2 should 1	유	1 ✓ Yes 2 27. Manner of Death	No		e of Injury	28b. Time of			ry at Work			now injury occu			
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	file ou		29a. Certifier	ertifying Phys	ician: To the be	est of my know	rledge, death occ	urred at th	e time, da	ate and pla	ace, and du	e to the caus	e(s) and manr	ner as sta	ted.	
	4 2 4 2	Medical	one) 2 V M	ledical Examii	ner: On the basis	of examination stated.	on and/or investig					ne time, date				
		Æ	29b. Signature and til	tie of certifier			0	29		e number			29d. Date si	- '		ear)
	WJL		(al)	111	11	7	V	>	O.C.	M.E.			Novembe	si 13, 2	.003	
	4		30. Name and addres					nn Ctr-	ot Ball	timoro	MD 2420	11				
			Zabiullah Ali,		sistant Med	egistrar's Sig		iiii Stre	et, Dali	uniore, i	MD 2120					<u> </u>
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Amend #19 a per Fh g901 3/10/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dolores Nov. 1, 2009 Ordonez Garcia 10:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Davs Hours Min Director 46 <u>216-31-4562</u> 11/02/1962 Salvador E1Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marical Examination in the profitted at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 Orange Wood Street 20905 El Salvador Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 ¹ El ² Salvadoran þ White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscape Landscape Co. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Luis Ordonez Virginia Garcia ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Orellana Ordonez Amanda Isabel Orellana Ordonez 14508 Orange Wood St.Silver Spring, Md20905 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Cemetery crematory of other place Cemeterio Nuevo 1 Burial 2 Cremation 3 Removal from State 11/12/2009 SansMiguel 4 ☐ Donation 5 ☐ Other (Specify <u>Eden de San Juan</u> 21. Signat In PHIDIP ADSRIALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 152068 **Physician** rona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be execute physician and the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Year Day 5 Other (specify) signed by the a □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Mellirus diabeles 1 Yes 2 No 3 Probably 4 Unknown Completed chroni Kionen 615-en58 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗆 No 1 ☐ Yes 2 XNo 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 4 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 [(LNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 74 M 006399 Molline 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11811 Prince Philip Dr. Olney, Md. 20832 Ata Motamedi M.D 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Man		artment of Hetificate of E			giene 100 9	37316		
j\$:	Physici		1. Decedent's Name (First, Middle, Last)		AMBR	ELL		2. Date of Dea Month		3. Time of Death		
>	/Medio Examir		4a. Facility Name (If not institution, give s Larkin Chase			4b. City, Town, or Bowie			4c. County of Dea			
	Funeral Director		5. Social Security Number 6. Sex 247–90–0649 Usual Residence of Decedent	7. Age (li	n yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 20	r, Year) Co	thplace (State or Foreign ountry) 1th Carolina		
	Maryland -f show list at	tor	10a. Stale 10b. County MD Prince Ge		Oc. City, Town or Lo	Bowie				10d. Inside City Limits 12 Yes 2 □ No		
	with the	Director	10e. Street and Number 15410 Neman Drive			10f. Zip Code 20716				Og. Citizen of What Country? USA		
980	d within 72 hours atter death with the Maryland Jiene. r than "natural", or Itema 23a or 28a-1 show The Madical Examinat routil be mailfied at	by Funerai		12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑XNo If Yes, Give Year or Dates:		Vas Decedent of His i Yes, specify Cubar	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	encan Indian,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical onge.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done di DO NOT use retired) Inventory	iring most of worki	ng	16b. Kind of Business Auto Part Warehouse	s		
land		To Be (17. Father's Name (First, Middle, Last) Capers M. Gambrell	l, Sr.			18. Mother's Name Jan	et Reed	Maiden Sumame)			
Mary		ì	19a. Informant's Name/Relationship (Ty) Suzanne E. Wilson/N			g Address (Street a. O Neman I			r, City or Town, State, 0716	Zip Code)		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1547451	natory or other place))ate	20c. Location - City or			
Baltir	permit. P Departme Importar any injur		21. Signalure of Funeral Service License			. Name and Address	of Facility	Beall 1	Baltimore, Funeral Hor			
23a. Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician (Medical resulting in death)								Approximate Interval Between Onset and Death				
41	/Medical Examiner			Due to (or as a co								
00,	death certificate be executed e attending physician and ad for use as the burial-transit	i Examiner	Sequentially list conditions, If any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
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P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	∃Fetal déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
	iaw requires that the as been signed by the 2 should be detache	Ď	Part II. Other significant conditions con	tribuling to death but n	•	, , ,	n in Part I.	23e. Did to	bacco use contribute to	o the cause of death?		
Division of Vital Records,	The la ate has page 2	Completed	HAPEI	RTENSIO	N			24a. Was a autops perform	an 24b. Were a prior to death? 2 No 1 Yes	utopsy findings available completion of cause of		
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	lospital:	2 ER/Outpatien	Other	26. Place of Death	1000	ence 6 Other (Spe	icity)		
sion of	gr en en		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dale of Injury (Month, Day Ye		28c. Injury Work			ow injury occurred	5.1)		
Divis	To the Hospital or Attendii within 24 hours after death. To the Funers! Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury - At nome, farm, street, factory, office 28f. Lo					treet and Number or R n, State)	ural Route Number,		
	he Hospi n 24 houn he Funer hetely fill	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurr	and due to the c ed at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)		
	Tot Tot	Σ	29b. Signature and title of certifier			29c. License		Ę.	29d. Date signed (Moni			
(44	1	30. Name and a drey's of pers to who co	mpleted cause of death	h (Item 23a) (Type, I	Print)	best rd	ځمره	eca DIC	my 20740		
3 · · · · · · · · · · · · · · · · · · ·	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 02 20	32. Registrar's		arked			0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Maryla		artment of F <i>tificate of L</i>			jiene _{leg. No.} 2 N N	0 3731
	Physic Med		1. Decedent's Name (First, Middle, Las Maria	Falcone Griff	ith			2. Date of Deat Month October	th	3. Time of Death
	Exam		4a. Facility Name (if not institution, give: 12014 Shagbark 1	street and number)	4b. City, Town, or Location of Death Rockville				4c. County of D	
	Funera Directo		5. Social Security Number 214-52-6216 Usual Residence of Decedent	x □ M 2 🖾 F 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 (Month, Day 1 1 / 2 6 / 1	g.	Birthplace (State or Foreign Country) USHUNG TON, DC
	s filed within 72 hours after death with the Maryland tal Hygiene. 40 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland Montgo 10e. Street and Number		ity, Town or Loc	eation	Rockvill	le.		10d. Inside City Limits 1 ☐ Yes 2 💆 No
	ath with th	uneral	12014 Shagbark D			10f. Zip Code	20852	1	0g. Citizen of What	Country?
9600	urs after de ural", or ite	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 	If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify:	
Maryland 21215-0036	iled within 72 hou Il Hygiene. other than "nat rent, <u>the Medica</u>	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12)	cation le completed) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	uring most of work	ing	16b. Kind of Busines	•
yland 2	id be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Vito Fa			Self-Em		e (First, Middle, Ma	tail	
e, Mar	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once,		19a. Informant's Name/Relationship (Typ Lucy Hamachek - S. 20a. Method of Disposition	ister	nd Number or Rura Road, Be	Lucia Finelli or Rural Route Number, City or Town, State, Zip Code) Bethesda, Maryland 20816				
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal are if Fundral & cryice Licensee	emoval from State F た	Place of Dispositemetery, crema Linco	tion (Name of itory or other place, Ln Cremax	toru 11	Date 2	Oc. Location - City	or Town, State
Ö	permi Depa Impo any ir		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	1010a MO[24	/	800 New H	ampshire	Ave. S	ldi Funera ilver Spr	ing, MD 20904
اراس م	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Cardiac A	Arrest				,	Approximate Interval Between Onset and Death MUNUTES
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or linjury	Due to (or as a consequ	ence of):					
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o Xox	death certifie attending at for use a	S I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	c. If yes, outcome of pregnan 1	death 3 🗆 E	ctopic pregnancy other (specify)			23d. Date of de Month	elivery Day Year
rds, P.O.	requires that been signed to hould be detailed to h	þ	Part II. Other significant conditions contr Crohn's Disease	ibuting to death but not resu	lting in the und	erlying cause given	in Part I.			o the cause of death?
vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Be Completed	25. Was case referred to medical examiner?			26 Place	of Death (Check o	24a. Was an autopsy performed 1 Yes 2	d? prior to death?	stopsy findings available completion of cause of
oding Dhysic	th. : After this ce e funeral direc	잍	1 1 Yes 2 No Hose 1 No Hose 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	pital: 1 ☐ Inpatient 2 ☐ E 28a. Date of injury (Month, Day, Year)	8b. Time of injury	DOA Other: 28c. Injury at work?	4 Nursing Hom		e 6 Other (Spec	ify)
ultal or Attendir	urs after dee ral Director Illed in by th	al Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street,	factory, office		City or Town, St	,	
To the Host	within 24 ho	Med	29a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse P. 9b. Signature and title of certifier	n: To the best of my knowled On the basis of examination a Actioner: To the best of my k	dge, death occu and/or investigat nowledge, deat	h occurred at the tin	ne, date and place,	and due to the cau	ace, and due to the o se(s) and manner as	cause(s) and manner stated. stated.
	15	3	0. Name and address of person who comp	eleted cause of death (Item 2)	3a) (Type, Print)		mber \$135	29d.	Date/signed (Month	n, Day, Year)
	State	3	Donna Rinis, M.D., 1. Date filed (Morith, Day, Year)	8901 Wiscons	in Ave.	. Bldg.	7, Bethe	sda, Mar	yland	
	Registra		NOV 0 5 2009	32. Registrar's Stopaton	gark	<i></i>				

Joselino Munoz-G	1	Oy - For State Registrar	State of I	Maryla		artment of <i>rtificate o</i> i	FHealth and F <i>Death</i>	d Mental F		Reg. No. 20	09	3731
Physician Medical Examin	1/	1. Decedent's Name (First, Joselino		Zodov					2. Date of De Month October	Day Year		3. Time of Death 2222 hrs
MA	ı	4a. Facility Name (if not ins	stitution, give stre	et and nur	mber)		4b. City, Town, or Baltimore	Location of Deat	th	4c. County of	Death	
Funeral Director		5. Social Security Number	6. Sex		7. Age (In yrs.		If Under 1 Yea Months Days			irth(MM/DD/YYYY) 20/1978	9. Birth Cour	place (State or Foreigr htry) Guatemal
any	-	Usual Residence of Deced	ent	2 F		, Town or Locat			00/	20/13/0		10d. Inside City Limits
. ₹	Director	Md F	rederic	<u> </u>	Fr	rederick	10f. Zip Code			10g. Citizen of Wha		1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must he notified at once.	_ 1	1326 Mulbe	12.	Was Dece	edent Ever in U	J.S. 13. Wa	21703 as Decedent of His es, specify Cubar	spanic Origin? (\$	Specify Yes or Note Rican, etc.)	Guatema Io- 14. Race - White,	Americ	an Indian, Black,
s after death	by Funera	Never Married 2 Widowed 4 Decedent's Education	Divorced if Ye	Yes es, Give Year pates:	2 X No	1 🗓	Yes 2 No	specify: Gua	temala	Specify:		panic
136 hin 72 hour e. than "natu	Completed	Elementary/Secondary		College (1			ost of working life			Lands		
	å	17. Father's Name (First, M Victoriano	Munoz					Gabri	ela God			
MD 21 d 2 should tht and Me an 27 is ma		19a. Informant's Name/Rei Rosa Alvarez			Ее	4				umber, City or Town		Zip Code)
Baltimore, I bernit. Pages I and Important: If item injury or other tra		20a. Method of Disposition 1 X Burial 2 Cre 4 Design 5 Ot	mation 3 🗍 F	Removal fro	om State	crematory or of	sition (Name of ce her place) Cemeter		Date	20c. Location - Guater		own, State
Baltil permit. Departm Importa		21. Signature of Funeral S	ervice Licensee	(X		3	3005 12th	n. St. N	E Washi	Rhines Fu ngton D.C	. 20	0017
Physician "Medical .aminer		23a. Part I Enter the disea re. List only one Immediate Cause (Final d or condition resulting in de	cause on each li isease a Mul	_{ne.} tiple Inju			he mode of dying,	, such as cardiac	or respiratory a	irrest, shock, or nea	n.	Approximate Interval Between Onset and Death
tred q	Exam	Sequentially list condition: if any, leading to immediat cause. Enter Underlying (Unscase or injury that into events resulting in death)	te Due Cause		consequence		_					
O, e be executed /sician and burial - transit	edical	UNPENDED		MENDED								
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res that the c	<u>۾</u>	Part II. Other significant	conditions cor	tributing to	death but not	resulting in the	underlying cause	given in Part I.		tobacco use contri ∕es 2 ✔ No 3	Proba	ably 4 Unknown
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ision of Vi		27. Manner of Death 1 Natural 5 2 Accident	Pending Investigation		2009 (2009)	28b. Time of 1736 hrs	1	ury at Work? Yes 2 ✓ No	Operator of object	of dirt bike that	collide	ed with fixed
Division popital or Attendia nor after death norsa after death norsa after death filled in by the fu	Certification:	3 Suicide 6 Homicide	Could not be determined	(Specify)	Roadway		eet, factory, office		or Town Gambrill Pa	, State) irk Road near To	wer Ro	ad, Myersville, MD
To the Hos within 24 h To the Fur	edical		al Examiner:On	To the bes the basis manner s	of examination	edge, death occu and/or investige	irred at the time, o ation, in my opinio	n, death occurre	nd due to the ca	ause(s) and manner ite and place, and d	ue to the	e cause(s)
2	W	29b. Signature and title of	certifier HA	00 c	1.10		29c. Licen	se number .M.E.		29d. Date signe October 30	,	
		30. Name and address of Carol Allan, MD	person who comp				Street, Baltim	nore, MD 212	201			
Sta Registi	ate rar	31. Date filed (Month, Day	5°2009	Seren Seren	egistrar's Sign	ture park	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2000 **Physician** 4:15p Lerov Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Svkesville Fairhaven Health Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 4 9. Birthplace (State or Foreign Country) Montana 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 89 1 □X M 2 □ F 704-01-2569 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State ir than "natural", or items 23a or 28a-f show MD Sykesville Carrol1 1 X Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21784 7200 Third Avenue M221 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specity only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) railroad vice president 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Health and Mental em 27 is marked o Emma Dukleth Eddie Grinde traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7200 Third Ave. M221, Sykesville, MD 21784 Leora Grinde (spouse) permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 11-6-09 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licens C topial Sanger S P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Varwlor Severa whereil Peri Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) P.O. | 1 □ Yes 2 □ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🔀 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/21 DOOLLOL 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Eldersbug Registra s Signature State Darks Leveren Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37320 State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4 2009 November 5:50a M Green Cleda Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 8/27/1924 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 400-28-8348 Kentucky Director 85 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Middell Examiner must be notified at 1 ☐Yes 2 ☐No Hampstead Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21074 17823 Marshall Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Marietta-Martin Aviation draftsman permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Sudie Little Harry Oliver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7214 Intersection Rd., Glen Rock, Pa. 17327 Debra L. Kidd, daughter Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Md. Hampstead Cemetery 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 934 S. Main St., Hampstead, Md. 21074 Lands Semme 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or es a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 tonknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medical examiner? Be Other: Hospital: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျှ 1- Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ⊿ Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera Certification: After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the dead of 29a. Certifier Medical (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D395029 MM 29 LILY 109
East hair of waterinster HA WA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosain 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 06 Barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of IVIa	aryland / Dep	ertificate of		, 0	ene _{9-No.} 2009	37321			
	Physic		Decedent's Name (First, Middle, Las Ra1	^{t)} pheal Whit	tnev Hamme	and		2. Date of Death Month November	Day Year 14 2009	3. Time of Death			
	/Medi Examir		4a. Facility Name (If not institution, give		circy Hammic		or Location of Death		4c. County of Death				
and .			Union Hospita1 5. Social Security Number 6. Se	7 10	. // logs birth do	E1kto:		T 0 5 1 1 1 1 1 1 1	Cecil				
	Funeral Director		213-38-5190	XIM 2DE	e (In yrs. last birthda) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG 8, 1	Year) 9. Birth Cou .941 Ma	place (State or Foreign intry) ryland			
	rand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
	Mary a-f sh	ctor	Maryland Cecil		E1kton					1 ☐ Yes 2 💢 No			
	or 28	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	ntry?			
	sath w		1016 Warburton Ro			2192			United St				
9	thin 72 hours after death with the Marylan e, an "natural", or items 23a or 28a-f show M.dfcal Evaminer must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 2 🏋 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	ever in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,				
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21	be filed with that Hygiene od other that event, the	Com	12	Conege (1-40r 5	*) C	ook/Chef			Health C	are			
and	Pages 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, it was dear the must be notified at	Be	17. Father's Name (First, Middle, Last) Evan T. Hammond					e (First, Middle, Ma	,				
ary		은	19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mai	ing Address (Street		. Alexand	City or Town, State, Zip	n Code)			
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Baltimore, Maryland	ges 1 and the life item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ I	Removal from State	John Diago of Diag	iti /\(\)			c. Location - City or To	wn, State			
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	To th within To th comp	ĕ	29b. Signature and title of certifier			29c. Licenso		29d	. Date signed (Month,				
			> Sachder-S				23322		11. 17.2	009.			
	8		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print) E fligh S1	FO	Eton MI	12/02/				
	Sta	~	31. Date filed (Month, Day, Year)	32. Registrar		1499	1	CW/) ///	12174				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 State Registrar 37322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 12:28 am LEROY ALEXANDER HICKS November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Medica Plata Centes Charles La 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6-7-1950 9. Birthplace (State or Foreign Months Days Hours Min. MD • 17 M 2 □ F 219-56-1419 59 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits CHARLES 1 ☐ Yes 2 🙀 No WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12592 MIRKWOOD LANE 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XTO Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER FARMING 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEO W. HICKS ALICE LOUISE WASHINGTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS DORSEY-COUSIN 12592 MIRKWOOD LN. WALDORF, MD. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHILOH METH.CEM. 11-20-09 NEWBURG . MD . 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 □ Yes 2 🗆 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examine burial-tran

Physician

/Medical

Examiner

10a. State

MD.

Funeral

Director

'natural", or items 23a or 28a-f show

other

permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic ever Pages 1 and 2 should be

event, the "hydical Examiner must be notified at

Director

Funeral

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Completed

Be

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with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

within 24 hours after death To the Funeral Director:

attending physician for use as the buria Physician/Medical signed I Completed Be Certification: To

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Part II. Other significant condition

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1 Yes 2 N	0	
1 X Natural	5 ☐ Pending	
	investigation	'n
	5	
3 ☐ Suicide	6 ☐ Could not be	9
4 ☐ Homicide	determined	
	examiner?	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be

28a. Date of Injury 28b. Time of (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29t	o. Signature and title	of certifier	0.		
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30	Nama and address	of porson wh	o and otod	course of death (-

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em 23a) (Type, Print) ite 101 Waldorf MD 20602

Date filed (Month, Day, Year)

Registrar

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State of Maryland / Depart	ment of Health	and Mental Hy	giene 20

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Dorsey Lee Hungerford /Medical October 0 30, 2009 8:55 p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10703 Inwood Avenue Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ty**□M 2□ F 218-16-0758 86 Yrs. Director AUG 02, 1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 10703 Inwood Avenue 20902 United States permit. Pages 1 and 2 should be filed within 72 hours after death 10 Department of Heath and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23, any injury or other traumatic event, Ite M. Affer Exmine many. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 XYes 2 No 1943— If Yes, Give 1945 Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify: Caucasian Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Contractor Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Hungerford Lillian ပ Petticord 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert William Hungerford/ Son 10703 Inwood Ave., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 11/03/2009 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Avenue, LL, Silver Spring, MD 20910 M00956 23a. Part 1. Ever the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant In the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARCINOMA OF THE LUNG 1 AYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? Yes 2\sumbox No 1 ☐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 Accident 2 □ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ht D0055522 11/02/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT H. GERARD, M.D., 1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signatu

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State

Registrar

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Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records.

			For State Registrar	State of Mary	land / Depa <i>Cel</i>	artment of H rtificate of	lealth ar <i>Death</i>	nd Mer	ntal Hygi	iene,	2009	37324		
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	Funeral Director		5. Social Security Number 6. S	□ M 2□XF	yrs. last birthday) Yrs.	Months Days		Min.	Date of Birth (Month, Day,		Cou	place (State or Foreign intry)		
			279-34-8860 Usual Residence of Decedent	70_				/	/31/39	,	MI			
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36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, I'm Mydicol Exon were useful to indiffice	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ₩ivorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent <i>o</i> f H If Yes, specify Cub 1 □Yes 2 X No		Puerto Rica	an, etc.)		Black, White,			
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Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot		1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Hemoval Irom State	Gate of H			1/9/0	9	Silv	er Spr	ing, MD		
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			30. Name and address of person who		. , , , , ,		notos	DC 3	00E7					
	Sta	te	Khaled El-Shami 31. Date filed (Month, Day, Year)	3800 Reservo	Signature	ivi, WasiiI	TIS COLL	DC Z	0037					
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Second Continued Continued				shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Sequentially list conditions, if any, leading to immediate contributions as a consequence of): Sequentially list conditions, if any, leading to immediate contributions are consequence of):	P		8 1	disease or condition a.	y Artery Disease		Onset and Death
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30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Thomas J. Verto M.D. 114 Business Ctr Dr Reisters town MD 2 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature	260	physi s the t		d			
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30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Thomas J. Verto M.D. 114 Business Ctr Dr Reisters town MD 2 State 31. Date filed (Worth, Day, Year) 22. Registrar's Signature	Box	ueann ne atte ed for	sicis	1 Ves 2 No 4 Pregnant at time of death 5			Month Day Year
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30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Thomas J. Verto M.D. 114 Business Ctr Dr Reisters town MD 2 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature	S, P	signe d be c	d by			1 □ Yes 2 €	No 3 Probably 4 Unknown
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30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Thomas J. Verto M.D. 114 Business Ctr Dr Reisters town MD 2 State 31. Date filed (Month, Day, Year) 22. Registrar's Signature		o the of the omple	ž				
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10				2	MD 2: -
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MILDRED A. HUMPHREYS 03-2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Haspica ct the Lake Krudziloz If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7-1-1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F MARYLAND 60 214-46-4820 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinar must be notified at any Injury or other traumatic event, it a Medical Examinar must be notified at any once. 1 ☐ Yes 2 🙀 No MARYLAND WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 US 29 MYSTIC HARBOUR BLVD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RENTAL MANAGEMENT REAL ESTATE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM G. SINNAMON SARAH MILDRED LYNCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAZEL A. WILLIAMS/SISTER 4925 CYPRESS GARDENS RD, WINTER HAVEN, FL. 33884 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 11-7-2009 BERLIN, MARYLAND 21. Signature of Fuseral Sep MELSON FUNERAL SERVICES, LTD 43 THATCHER STREET, FRANKFORD, DE. 19945 Approximate Interval Between Onset and Death 23a. Part 1. Inter the dilyeas i, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CHRONIC **Physician** /Medical THROW BOSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence ther (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injuly occurred 1 □ Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stay Buy BA 10 6 Huyan WA 31. Date filed (Month, Day, Year) State NOV 0 4 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month John Alvin Hill 2009 8:09 Рм October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec. 17, 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Days 1 XM 2 □ F Months Hours 202-26-6106 Director 72 Pennsylvania 1936 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a supplicitly injury or other traumatic event, the Medical Examiner must be a Funeral 293 Cedar Lane 21403 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. rmed Forces?

XYes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1958-61 Year or Dates. White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Milkman Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Bertha Brickner 2 Joseph Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Hill/wife Annapolis, Maryland 293 Cedar Lane Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place) Baltimore Crematory 11/5/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) era Service Licen 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate l 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မှ 1 ☐ Inpatient 2XXER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Certifica Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one d title of certifie 29b. Signature 29c. License number ٥ October 29, 2009 D16376 0/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4+1 Joseph D. Moser, MD 2001 Medical Parkway Annapolis, Maryland

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) NOV 02

2009

oistrar's Signature

Registrar Decedent's Nam				Car	tificate of		Mental Hy	-		0	2722
	no /First Middle I	not)		Cer	uncate or	Deam	2. Date of De		200	9	3732
- OCOLEC		Harshaw, Sr	-				Month Nov.	Da	^y 2009 ^Y	'ear	3. Time of Death 6:48 A
• ,		ive street and number,			4b. City, Town, o	r Location of Deat	h		. County of		
	cefield I			41. 1	Silver S		T = 5		ince		
. Social Security N	2285	Sex 7. Ag	ge (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ay, Year)		Countr	ce (State or Fore y) Carolin
Jsual Residence o 0a. State	of Decedent 10b. County		10c. City, Town	or Loc	cation						d. Inside City Lim
MD	Prince (George's		Silv	ver Sprin	ng					1 □Yes 2 □ I
0e. Street and Nu		n.a. #500			10f. Zip Code			10g. Cit	tizen of Wha		y?
1. Marital Status	ceriera F	Rd., #523	Ever in LLS	13 V	20904	lienanic Origin? (9	Procify Vo.s. or No		US.		a Indian
	ried 2 Married	Armed Forces?	No		Vas Decedent of H iYes, specify Cuba □Yes 2∑No	an, Mexican, Puer Specify:	to Rican, etc.))-	14. Race - Black, Specify:	White, etc	D.
-	15. Decedent's E	Education		Deced	ent's Usual Occup	ation	rkina	16b. K	ind of Busir		
Elementary/Seco		College (1-4or !		life. D	OO NOT use retired	1)	g	т .: 1.		~ F ~	
7. Father's Name	(First, Middle, Las			LTOI	carian	18. Mother's Nar	ne (First, Middle			OI C	ongress
	n Harshav	*					ia Gibb				
	lame/Relationship		19b.	Mailing	g Address (Street				or Town, Sta	ate, Zip C	Code)
Lois G.	Harshaw,	, wife			Gracefiel						
Oa. Method of Dis	sposition	Removal from State			sition (Name of latory or other plac		Date		ocation - Cit		
4 Donation	5 ☐ Other (Spec	eify)	Resurre		Lon Cemet						D
1. Signature of Fu	uneral Service Lice	ensee	14	Ďδ	Hame and Voidre	Borgward	t Funera	al Ho	ome, I	PA	
On Part I Entari	the disease of the	mplications that caused			00 Powde				lle, N		Land 2070 Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Metastatic Prostate Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										10	years
nat initiated events	S	bDue to (or as	a consequence o	of):		L					years
nat initiated events	Last to pregnant months?	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of a consequence of pregnancy	of): 3 🗆	Ectopic pregnanc Other (specify)				23d. Date o Month	of delivery	
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Stat Registra

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		-	For State Registrar	Sta	ate of Ma	aryland			nt of H <i>te of L</i>	ealth and N Death	/lental Hy	giene Reg. No.			
			1. Decedent's Name (First, Mic								2. Date of De	ath	ZUU:	3. Jim o	3.29
	Physicia /Medic		Carolyn Fa	y Heid	lenrei	.ch					Novemb			1:00	Ам
	Examin	er	4a. Facility Name (If not institut		and number)					Location of Death			County of Dea	th	
	Funeral		4230 Tupelo C 5. Social Security Number	6. Sex	7. Age	e (In yrs. la	st birthday)	If Unde	er 1 Year	public If Under 24 Hrs.	8. Date of Bir	th (Carl	Calvert 9. Bir	thplace (State	or Foreign
	Director		366-58-6939	1 □ M 2	° CxF	57	Yrs.	Months	Days	Hours Min.	8. Date of Bir	1952	Mid	higan	
	and w	}	Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. City,	Town or Loc	cation						10d. Inside C	ity Limits
	Maryli fed at	to	Maryland Cal	vert		Po	rt Rep	oub1i	LC					1 ☐ Yes	2 No
	th the	Direc	10e. Street and Number					10f. Z	ip Code				zen of What Co		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show sical Examinar must be motified at	Funeral Director	4230 Tupelo C						20676				ted Sta		
_	iter de	Fune	 Marital Status Never Married 2 ☒ M 	Ar	as Decedent E med Forces? ∐Yes 2 🛣		i. 13. V	Was Dece f Yes, sp	ecify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit		
2-003p	ursaf al", or	by	3 ☐ Widowed 4 ☐ Divorce	If	Yes, Give ear or Dates:		1	l∐Yes	2 🔀 No	Specify:			Specify: whi	ite	
<u>0</u>	72 ho	Completed	15. Deced (Specify only hig	ent's Education hest grade com	pleted)		16a. Deced	dent's Us kind of w	ual Occupa	ation luring most of work)	ing	16b. Ki	nd of Business	/Industry	
7	within iene. than "	duic	Elementary/Secondary (0-12	() Co	ollege (1-4or 5	+)	food					gro	cery st	core	
and 2	e filed Il Hygi other	Be C	17. Father's Name (First, Midd							18. Mother's Nam			Surname)		
yıar	should be and Mental marked c umatic eve	To E	William Russe	11 Col1	ingham					Dorothy	Wicket	t			
Mar	AS E E		19a, Informant's Name/Relation					-		and Number or Rui		-			
e,	1 and Healt tem 2		Robert D. Hei 20a. Method of Disposition	<u>denreic</u>	n- spo					ourt Port Nov 9 2			cation - City or		
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	(Specify)	al from State	Ches	apeake	e Hig	gh1an	ds Memori	al Gar			-	MD
Бап	Depar Impor any in		21. Signature of Euneral Servi	ce Licensee						s Is. Rd.					
			23a. Part 1. Enter the disease shock, or heart failure. L	or complication	ns that caused use on e way lir	the death.	. Do not ent	-	_		-	ırrest,		Approximate Interval Bet Onset and	tween
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	H	tru	al	til	nil	lation	n			Onset und	
	Examiner		,		Due to (or as	a consequ	ence of):	asl	uli	n Ac	cicles	rt			
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	ecute and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	<u> </u>	gul	DAI	77 hr	1					
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98/90	tificate ig physas the	ledical		a											
X Q Q	eath certifi attending for use as	an/IN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		yes, outcome □ Live birth			Ectopic	pregnancy	/		hki	23d. Date of de		Year
Ö.	the death by the atten ached for u	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown		☐ Pregnant a ☐ Unknown	t time of de	eath 5	Other (specify)				WOILI	Day	Teal
J.	w requires that the de been signed by the should be detached		Part II. Other significant cond	litions contribut	ing to death b	ut not resu	Iting in the ur	nderlying	cause give	en in Part I.	23e. Did	tobacco u	se contribute t	o the cause of	death?
Vital Records,	requires that been signed b hould be deta	ed by									1 🗆	Yes 2	No 3□ P	robably 4	Unknown
ဓင္ပဝ	12 B B	Completed									24a. Was		24b. Were a	utopsy findings completion of c	available ause of
<u> </u>	The sate	Con		27-0.0								ormed?	death?	3 2 □No	
VII.	Physician: The rule certificate ral director, pag	Be	25. Was case referred to med examiner?	ical Hospita	al: . 🗔				Othe	26. Place of Deal					
ō	g Phy er this eral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death		a. Date of Inju	iry	28b. Time of		28c. Injury Work	4 Nursing H	28d. Describe			ecity)	
ö	ath. ath. or: Aft	atio	Z LI Addidont	estigation	, ,		Injury	М	1 🗆	Yes 2 □No					
Division	after de Directo d in by t	Certification:		uld not be ermined 28	e. Place of Inj building, et	ury - At hor c. (Specify	me, farm, str	eet, facto	ry, office		28f. Location (Cify or To	Street an wn, State	d Number or R)	ural Route Nun	nber,
	To the Hospital or Attending Physician: within 24 hourst after death. To the Funeral Director After this certific completely filled in by the funeral director.	edical C		cal Examiner:		f examinat				ne, date and place pinion, death occu					5)
	To the within To the comple	Med	29b. Signature and title of cert					2	9c. Licens				te signed (Mon		
			1	TOLU	~				D517			11/	05/2009	<i>•</i>	
K	W 10		30. Name and address of pers Dr. K. Larse						rick,	MD 20678	3				
N	Sta Registr		31. Date filed (Month, Day, Ye	ov - 5 2	32. Registr	as Signat	ure A.	Sol	wes						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harry W. Holloway 3, November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Worcester Berlin If Under 1 Year | 1f Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 69 Director 221-26-1874 1940 July 20, Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, I'w in digal Even, item is ust be not liked at Director DE Delmar 1 ☐ Yes 2 😿 No Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17014 Whitesville Road 19940 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No dates 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Myes 2 No dates If Yes, Give Year or Dates unknown 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Poultry Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, Unknown Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana R. Holloway (Wife) 17014 Whitesville Road Delmar, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery Nov. 7, 2009 Laurel, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. Short-Vewell Delmar, DE 19940 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** shock /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Corchary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy The After this certificate perform 2 No Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0064120 148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A G H 9733 Health way Inive Berlin Zees han.

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State o	of Marylar						lental Hyg	giene	• • •	07001
			State Registrar			Cei	rtificate	e or L	Jeath			leg. No.	009	37331
	Physicia	an	1. Decedent's Name (First, Middle Blanche Iren		ger						2. Date of Dea Month Novembe	Day	2009	3. Time of Death 10:10a M
4	/Medic		4a. Facility Name (If not institution				4b. City,	Town, or	Location	of Death		_	ounty of Death	1
	Examin	er	Carroll Luther				West	mins	ster				Carrol:	1
	Funeral			6. Sex	7. Age (In yrs.	. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birth	nplace (State or Foreign
	Director		215-12-1970	1□M 2√xF	89	Yrs.	WOTHIS	Days	Tiours	IVIII).	Sept 28	1920	0	MD MD
	p		Usual Residence of Decedent		100.0	ity Town or Lo	ontion				5"			10d. Inside City Limits
	srylar show	<u>_</u>	MD 10b. County Carrol	1		ity, Town or Lo Westmin								1 □ Yes 2 No
	8a-f	Director					10f. Zip	Codo			1.	Ing Citize	n of What Cou	
	with the	ä	10e. Street and Number 205 St. Mark W	av				1158	₹			USA	11 01 1111111 000	
	eath v	Funeral	11. Marital Status		edent Ever in U	J.S. 13. V				igin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer	ican Indian,
	fter d ritem	듄	1 ☐ Never Married 2 ☐ Marri	ed 1 Tes	orces? 2 🛛 No						Rican, etc.)		Black, White	
e O	filed within 72 hours after death with the Maryland Hygiene. Hygiene. The Warland wither than "natural", or items 23a or 28a-f show ent, the Maddeal Evanding of the California of the Maddeal Evanding.	þ	3 X Widowed 4 □ Divorced	If Yes, G Year or D	ive Dates:		1 □Yes 2	2 X 1 No	Specify.	;		S	pec <i>ify:</i> Whil	te
2-0	72 ho	Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa k done d	ation during mos	st of worki	ng I	16b. Kind	of Business/I	ndustry
21	ithin ne.	ğ	Elementary/Secondary (0-12)	1	1-4or 5+)		oo not us irdre					cosi	metolog	37
2	e filed wal Hygier other the		17. Father's Name (First, Middle,	Last)		Ha	11111	3361		er's Name	(First, Middle,	Maiden Su	ırname)	
anc		Be	Jesse Triplett	*							teinman		mamoy	
Maryland 21215-0036	should be ind Mental marked o	ဠ	19a. Informant's Name/Relationsl	nin (Tyne Print)		19b. Mailir	na Address	(Street a	and Numb	er or Rura	al Route Numbe	r. Citv or T	own, State, Z	ip Code)
<u>s</u>	d 2 s Ith ar 27 ls trau		Allen Triplett		son)		-				ry, MD 2	-	, ,	•
ē,	thealth Health tem 27 other to		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Nan	ne of	1		Date		tion - City or 1	Town, State
و 1	Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Sp:	ringfie	ild Ce	emete	ery	11-09	9-09	Syke	sville	, MD
Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21. Sign sure of Funeral dervice		+	22	2. Name an	d Addres	ss of Facili	ity Ha:	ight Fur	neral	Home &	& Chapel
m	any per		populações	my	morsig	F	.O. E	Box 1	195 S	ykes	ville, N	1D 21	784	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not ent	ter the mod	e of dyin	ig, such as	s cardiac	or respiratory ar	rest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to	(or as a conse	quence of):								
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):							1,0	
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8760,	Attending Physician: The law requires that the death certificate be executed st death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical E												
687	ificate g phys	edic		0										
Вох	leath certific attending p	M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregrebirth 2 - Fet		☐ Ectopic p	regnance	v			230	d. Date of deli	
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of	ding Physician: The n. After this certificate h funeral director, page	은	1 Yes 2 No 27, Manner of Death	1	Inpatient 2 [e of Injury	28b. Time o		DA Our	4 A N		me 5 Resid			oify)
L C	ding F	ä	1 Natural 5 ☐ Pendin	g (Mo	onth, Day, Year)	Injury	м	Worl	k? Yes 2 ⊑		200. 2000,20			
Division of Vital Record	or Attendater death	lical	3 Suicide 6 Could	not be 28e. Plac	ce of Injury - At	l home, farm, sti	reet, factor		-				Number or Ru	ral Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	one)	and ma	nner stated.	and/or II	-			.au r oocul				
	To t To t	Σ	29b. Signature and title of certifie	-		\	29		e number	701			signed (Montl	
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	job 6		30. Name and address of person	who completed car	use of death (It	. 1	Print)		610	ctm	inste	E in	NO Z	1157
		ate	M. PANSURLY 31. Date filed (Month, Day, Year)	7 34	Registrar's Sign	nature	175		146	J (11		, , ,		/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Christine Ann King 3:20 p November 2009 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13211 Osterport Drive Silver Spring Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min 1 M 2 X F Yrs Director 178-34-6323 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🕱 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 13211 Osterport Drive USA 'natural", or items death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If item 27 is marked other ***:
any injury or other traumary. 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 ☐xNo If Yes, Give Year or Dates. 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Financial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Alvin Letowt, Sr. Merle Barnes 19a. Informant's Name/Relationship (Type, Print)
Walter I. King/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13211 Osterport Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Nov. 20c. Location - City or Town, State 3, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21, Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 months Immediate Cause (Final Head and Neck Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No perform certificate 2**X** No 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

Hospital 24 hours within 2

> Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier (Check

3 [

Paul Thambi, MD

NOV 04

au

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of contifier

31. Date filed (Month, Day, Year

MD

back

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D61083

9707 Medical Center Drive, Rockville, MD 20850

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

200

NOV.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08786 State of Maryland / Department of Health and Mental Hygiene Albert John Koehler 2009 37333 3. Time of Death 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 12, 2009 1220 hrs Medical Examiner Albert John Koehler 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery 1215 East West Hwy #1002 Silver Spring If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6 Sex 5 Social Security Number **Funeral** Hours Months Days NOV 01, 1944 Country) Director 65 324-36-9997 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 X No 23a or 28a-f show notified at once. Silver Spring Montgomery Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 20910 1215 Est West Highway, #1002 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Mantal Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married No 1967 Specify: Caucasian . Pages I and 2 should be filed within 72 hours after innert of Health and Mental Hygiene.
-tant: If item 27 is marked other than "natural" o Yes 2 X No specify: Divorced If Yas, Give Year -1969ð 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than ' Baltimore, MD 21215-0036 Real Estate Real Estate Broker 4 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Smith Elva Ε. Koehler Be Adolph S. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #900, Silver Spring, MD 20910 Karen Koehler Egeland/ Sister 8484 16th Street, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/15/2009 Glen Burnie, MD Atlantic Crematory Donation 5 Other Specify 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. 21. Signature of Fytheral 25. M00956 MD 20910 933 Gist Ave., LL, Silver Spring, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death 'Medical Hypertensive atherosclerotic cardiovascular diseas aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED **AMENDED** attending physician or use as the burial -23a,27,permE, g897 11.23.09 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for q Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? has ✔ Yes 2 1 🗸 Yes No certificate page 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Hospital: 1 examiner? Other 1 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 Inpatient this 1 Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 13, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

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31. Date filed (Month NOV

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Registrar's Signa

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Physici /Medic		Barbara	Baron B	Klein						Novemb	er $\overset{ extsf{D}}{2}$, 200 ⁹	ear	9:30	РМ
Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, 7	Town, o	r Location of Deat	h		c. County of	Death		
				ventist Hosp			Ro If Under		ille	T		ontgor			
Funeral Director		5. Social Security N 120–14–6		1 M OFFE	e (<i>in yrs.</i> . 35	last birthday) Yrs.	Months	Days	If Under 24 Hrs Hours Min.		Day, Year	7)	Count	ace (State o ry) York	r Foreign
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t Heal f Heal ftem 2		20a. Method of Dis			20b. P	890 N lace of Disposemetery, cren	ew Ma	rk e of	Esplanad:	e, Rock	7 111 20c. L	e, MD ocation - Cit	208 by or Tov	50 vn, State	
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ratural", any injury or other traumatic event, the Medical Exagnoce.		21. Signature of Fu	uneral Service Li	censee	-1	22	. Name and	Addre	ss of Facility Jo	seph Gav	wler	's Sor	s I	nc.	
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e dea the att	sicia	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 ☐ Pregnant at 9 ☐ Unknown			Other (spe		y			Month		Day Y	'ear
that the sed by detack				s contributing to death bu	it not resu	ulting in the un	nderlying ca	use dive	en in Part I	23e. Did	tobacco	use contribu	ite to the	cause of d	eath?
The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the I	d by			o contributing to goddin be		and g in the di	idenying out	doo give	or are i.			!□ No 3[Inknown
w req s beer	lete							·		24a. Was	an	24b. Wei	e autop:	sy findings a	vailable
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clan: ertifica	Be C	25. Was case refer examiner?	red to medical						26. Place of Dea	th (Check only	-/-	, ,,	165 2	- LINO	
Physic this c	၉	1 ☐ Yes 2 🔀	-			ER/Outpatien			4 LI Nursing H	ome 5 ☐ Res			Specify)		
ding h. After funer	tion	27. Manner of Deat 1 Natural 2 Accident	5 □ Pending investigat	28a. Date of Injui (Month, Day	ry v, Year)	28b. Time of Injury	M 28	ic. Injur Work 1 □¹	yat :? Yes 2 □ No	28d. Describe	how inju	ry occurred			
Atten r deat sctor: by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	t be 28e. Place of Inju	ıry - At ho	me, farm, stre				28f. Location	Street a	nd Number o	or Rural .	Route Numi	 ber,
tal or s afte al Dirrection	Certification:	4 🗆 Homicide		building, etc	. (Зресп)	<i>(</i>)				City or To	wn, Stat	e)			
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	í⊠ Certifying 2□ Medical Ex	Physician: To the best of caminer: On the basis of	examina	wledge, death tion and/or inv	occurred a restigation,	t the tir	ne, date and place pinion, death occu	e, and due to the	cause(s	s) and mann d place, and	er as sta due to t	ited. he cause(s)	
ithin 2 o the	Medical	one) 29b. Signature and	title of certifier	and manner sta	ted.		29c.	License	number		29d. Da	ate signed (A	fonth. D	av. Year)	
3		1	roll	m	0				8112			/04/20		y,/	
	}	30. Name and addr	ress of person wh	no completed cause of de	eath (Item	23a) (Type, F	Print)								
				shian MD 990			Cente	r D	rive Rocl	cville,	MD :	20850			
Sta Registr	-	31. Date filed (Mon	ith, Day, Year) 1 0 5 200	32. Registra	ır's Signat	Jan K	1								
		NUV	0 0 200	o parent	101	CI									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2005 A^{M} Stanley Leo Kingsbury, 6:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2640 Beaver Dam Road Calvert Chesapeake Beach Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours Wash. Director 578-22-2825 84 D.C. Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. But if item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4014 9th Street 20714 U.S.A 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give 1943–46 Year or Dates. 1 ☐ Yes 2xx No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor Washington Gas Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Stanley Leo Kingsbury, Elva Fincham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothea R. Kingsbury 4014 9th Street North Beach, MD 20714 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 11-6-2009 Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane Owings, MD 20736 23a. Part Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ 4theroscieronic Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Fibrillotion. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Multiple Cerebrovascular Accidents 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Mulh infanct DemenH'4. Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 ☑ No Other: 4 \square Nursing Home 5 \square Residence 6 ot M Other (Specify) daughter's1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred home 1 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 29b. Signature and title of certifier

851.

31. Date filed (Month, Day, Year)

wond

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

NOV

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number **D** 50653

Road.

GYAN.C. SURAWA

Deale mo

29d. Date signed (Month, Day, Year)

11-3-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Elizabeth Townsend Leach 27, /Medical <u>October</u> 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing Home Crownsville Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2X F 227-44-7267 **Director** 98 <u>6/20/1</u>911 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Ne Alco Examiner must be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 ☐ No Crownsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 Fairfield Loop Road 21032 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 🙀 No Specify: \$ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Langdon Townsend Rosa Flowers Pittman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Miller - Daughter 2509 Lyon Drive, Annapolis, MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 11/4/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Baltimore, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Mylin Wobert 147 Duke of Gloucester St, Annapolis, MD21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YMUEN disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.0. ned by the a 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed certificate 2 No Division of Vital 1 ∐ Yes 2 (X) 1 □Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A pletely filled in by the fu after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State

2

29b. Signature and title of contifier

NOV 02

person who completed cause of

2009

30. Name and address of

Registrar DHMH 17 Rev 1/2001 eath (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 IUMINO 00.05 4a. Facility Name (If not institution) give street and number) City, Town, or Location of Death 4c. County of Death HOPKINS 6. Sex Johns If Under 24 Hrs. 8. Date of Birth Hours Min. 8 / 0 3 / 1 9 5 8 5. Social Security Number (In yrs. last birthday) If I Inde 9. Birthplace (State or Foreign Months Days 1 X M 2 □ F 51 China 115-76-0506 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Montgomery Silver Spring 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 10518 Pennydog Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married Specify: Asian If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peng Liu Hui Yang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10518 Pennydog Lane Silver Spring, Md20902 Sheng Liu/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 □ B₄e Parklawn Mem.Park 11/09/2009 Rockville, Md. 4 Donation 5 Other (Specify 21. Signature of Funeral Se PHYLLIP ACTOR ACTION ALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespirate. disease or condition resulting in death) Due to mr as a consequence of): nerectie Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy ☐ Ectopic pregnancy Other (specify) underlying cause given in Part I.

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Exami

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

Director

Funeral

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Completed

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d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eval. The marked to Author the Medical Eval.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any injury or other traur

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the burial signed by the a d be detached for icate has been siç ; page 2 should b certificate funeral director, After this death.

Division of Vital Records, P.O.

Physician/Medical

ě

Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5
ontributing to death but not resulting in t	he
	4 ☐ Pregnant at time of death

		3d. Date of de Month	elivery Day	Year	
	23e. Did tobacco us			of death?	
	24a. Was an autopsy performed? 1 □ Yes 2 □ No	prior to death?	utopsy findi completion s 2 \(\text{\text{\$\ext{\$\texit{\$\text{\$\text{\$\texi}\$\$\$}}}\$}\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\	ings available of cause of	
h (C	heck only one)				
me	5 ☐ Residence 6	☐Other (Spe	ecify)		

25. Was case referre	ed to medical		26. Place of Death (Check only one)									
1 Yes 2	lo	Hospital	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home					Home 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28 <i>e</i> .	Place of Injury - At h building, etc. (Speci	nome, farm, stree ify)	t, fact	ory, of	fice	28f. Location (Street and Number or Rural Route Number City or Town, State)				

29b. Signature and title of certifier

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WW north Weike St. Baltimere, MD, 2/25 7

Registrar

31. Date filed (Month, Day, Year) 04

NO

To the Hospital or Attend within 24 hours after death To the Funeral Director:

filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GWENDOLYN J. LEWIS $P^{\ M}$ NOVEMBER 06 2009 6:07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 133-42-3446 57 APRIL 16, 1952DISTRÍCT COLUMBIA Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Experient must be notified at 1XYes 2 No Director MARYLAND HARFORD ABERDEEN 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 80 E. BELAIR AVENUE, APT A2 21001 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 **AFRICAN** 1 ☐ Yes 2X No Specify ş 3 ☐ Widowed 4 ☐ Divorced **AMERICAN** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RESPIRATORY THERAPIST HOSPTIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi r and Mental ⊦ Is marked otl Be JAMES ALEXANDER LEWIS, III ELNORA LEE PAYTON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD E. LEWIS, JR / HUSBAND 80 E. BELAIR AVENUE, APT A2, ABERDEEN, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. GARRISON FOREST VET 11/16/09 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licensee MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JASTROIN TEST Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending ph for use as the IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No or Attending Physician; After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death . Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only within 24 To the F and manner stated.

State

JWENDO/YN

, RAJAGOFALA RAO, MS TRIPURANENI 31. Date filed (Month, Day, Year) 62. Registrar's Signature NOV 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

UNION AVE HAVRE de GRACE, MD21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER Dorothy Jean Lytle /Medical Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death Examiner LAPLATA VISTA MEDICAL ENIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2/1XF Days Hours 201 28 8080 74 Director 1935 Pa Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Everyment must be maifind at Capitol Heights 1 ☐ Yes 2 XX No Maryland Prince George Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20743 United States 1132 Quo Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐¥es 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Beatrice Dunlap Jasper O'Dell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tran Joanne Boyle (Daughter) 6579 Lilly Road, Houston, MO 65483 Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Lee Crematory Nov 7, 2009 Clinton, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Lee Fuenral Home, Inc 6633 old permit. 21. Signature of Funeral Se 069 Alexandria Ferry Road, CLinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line schemic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to for sells consequence of Examiner and burjal-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial To the Hospital or Attending Physician; The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physiciar. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 ☐Yes 2 DNo 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 res 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier ▼Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific completed cause of death (Item 23a) (Type, Print) Name and address of person w LaPlata Md. GARRETT iwayne Thom 31. Date filed (Month, Day, Year, 32. Registrar's Signature State NOV 0 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2130 P^M 2009 November 16 Pauline R. Murson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year, Social Security Number 6 Sex 7. Age (In vrs. last birthday, **Funeral** Days Months Hours 1 □ M 2 🕅 F 79 March 16, 1930 Marvland 213-26-6248 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🛛 No Director Maryland Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 United States 100 Blossom Lane by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 💢 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Electrical Motor Elementary/Secondary (0-12) College (1-4or 5+) Assembler Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Heath Elmer Ruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard S. Murson/Husband 100 Blossom Lane, Elkton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Memorial Park 20, 2009 Elkton, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed 1-7 40 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day 1 ☐ Yes 2 No signed by the at d be detached fo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X10 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has 1 ☐Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 🗖 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the f Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Within 24 hours are.
To the Funeral Dir 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar Signature

222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)			Timeate of L	Jean	2. Date of Dea	ath 26	109	3 7 3 4 1
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	Funeral		Social Security Number 6. Sex	7. Age (In	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	lace (State or Foreign
	Director		205-34-4085	65	Yrs.	William Bayo	1,00.0	SEPT 29	, 1944		sylvania
	and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation				1	0d. Inside City Limits
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lar,	and I		19a. Informant's Name/Relationship (Type.	. Print)	19b. Mail	ling Address (Street a	and Number or Run	al Route Numbe	er, City or Town,	State, Zip	Code)
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 the hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	in the past 12 m 1 Yes 2, 9 Unknown	nonths?	4 🔲 i		2 Teta		☐ Ectopic ☐ Other (s	pregnanc specify)	У				Moi		Day	Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar/MFND#12perFH, 11/6/09, BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:00 aM nder11 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14312 Hollyhock Way Burtonsville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1⊠M 2□F Yrs 79 India Director March 17, 1930 577-92-0540 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner, must be notified at 1 XYes 2 No Director Maryland Montgomery Burtonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20866 U.S.A. 14312 Hollyhock Way Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 ♣ No Specify: Specify. 2 Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the I'm doonce. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amar Singh Manco Lajwanti Kaur Bhullar ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14312 Hollyhock Way, Burtonsville, Maryland 20866 Daphne K. Manco - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 11/03/2009 Brentwood, Maryland 21. Signature of Funeral Service Urense 22. Name and Address of Facility 110070 Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 ON or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failule Approximate Interval Between Onset and Death Immediate Cause (Final enoschtro **Physician** YEAVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a d be detached for 1 Tyes 2 No. Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 20 No 1 ☐ Yes 2 No After this certification funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Michael E. Leibowitz,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D., 11120 New Hampshire Avenue, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 2009 7:29 Miller Miller рм William С. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 13237 Clifton Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Yea ine 15, 1 🔀 M 2 🗆 F Months Hours Min Country) Indiana 79 930 Director 579-42-0711 June Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 😾 No Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 United States 13237 Clifton Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 ☑ Yes 2 □ No If Yes, Give Year or Dates.Korean War 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 - Widowed 4 - Divorced Completed White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Judge Maryland Circuit Court 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Flora Miller Homer Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13237 Clifton Road; Silver Spring, MD 20904 Anne Miller / Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 DRemoval from State Lincoln Crematory 11/4/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsy perform death? 1 Yes 2 No Yes 2 X No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 x No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title, 29c. License number 29d. Date signed (Month, Day, Year) 9+1 D62590 November 02, 2009 erson who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive; Silver Spring, MD 20902

State

Registrar

31. Date filed (Month, Day, Year)

NOV 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
State
Registrar AMEND#20a, b, cperFH, 11/5/09, BMW, Mcco-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Mack October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner paltimore 011 Johns HOPKINS HUSIDITA Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** -49-8254 Months Hours Min. 1 X M 2 ☐ F Days COlorado Director Usual Residence of Decedent County 10c. City, Town or Location 10a. State 10b 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the livedies Examinar must be notified at 1 ☐Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 2219 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates 992 - 2009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It all Institutions or other traumatic event, Ital Ins College (1-4or 5+) Elementary/Secondary (0-12) 57 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, 20a. Method of Disposition 20b. Place of Disposition (Name Arcamency Leviston at the 1 ★Burial 2 □ Cremation 3 ▼ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torchinsky Funeral Home, 21. Signature of Forerel Ser #4010 20012 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or is a consequence of): 3 mouths disease or condition resulting in death) /Medical Examiner 5 months J-Coute Must be designed S s any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò icate has been si 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 62-000 MA Waln 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) worke st. Baltimore MD 21287 Brown MD 600 N 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

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artis.

Physician
/Medical
Examiner

Funeral Director filed within 72 hours after death with the Maryland

r than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than" any injury or other traumatic event, the Magnesians.

Saltimore, Maryland 21215-0036

Physician /Medical Examiner The law requires that the death certificate be executed burial-tran and physician sthe burial Box 68760, attending pl P.O. I s been signed by the s of Vital Records. cate has be page 2 s his certificate h I director, page To the Hospital or Attending Physician: this After thi funeral Division death. within 24 hours after death

To the Funeral Director;
completely filled in by the f JRW State

1. Decedent's Name (First, Middle, Last) Day NOVEMBER PHYLLIS IONE MCGOWN 2009 7:49 AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 11 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 53 Months Days Hours 1 □ M 2 😿 F 220-66-9511 1956 Washington, DC Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director MD Calvert Owings 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9140 Nana Russell Road 20736 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ∐Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Information Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert M. Cook Patricia Undercoffer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McGown (husband) 9140 Nana Russell Road Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov I1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Southern Mem. Grdns. Dunkirk, MD 4 Donation 5 Dother (Specify) 2009 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service License Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final week disease or condition resulting in death) Due to (or as a consequence of): week Respiratora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence Examiner Days to fee weeks neumonia Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by host 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 1 ☐ Yes 2 ☐ No 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Year) 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 MD038119 DC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERNARD KIM 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registra Signature

Registrar

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month **Physician** 0615 AM ronick ora /Medical 4b. City, Town, or Location of Death 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Hours Davs 86 216-16-0067 Rison, MD **Director** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Its. I edical Eventing counts to notified at 1 ☐ Yes 2 No Director MD Prince George's Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 20774 USA 16707 Queen Anne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Sales Representative Wholesale Products 12 should be filed w h and Mental Hygier r is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elva Rebecca Milstead Benjamin Otis DeLozier ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur 16707 Queen Anne Road Upper Marlboro, MD 20774 Michael Myronick (husband) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 9. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2009 Cheltenham, MD Fineral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature Gary J. Goff 20736 8125 Southern Maryland Blvd. Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebral Artery Stroke Middle Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine fibrillation burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2/No Renal failure 1 Tes 3 Probably 4 Unknown director, page 2 should Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a Was an has certificate Heart tailure of Vital I or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a To the Funeral D 0 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nail 129 Sumau MD D53813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 12 Morte R. Dumais, MD Medical Placy. Annapolis, MD 2001 31. Date filed (Month, Day, Year) 32. Registra s Signature State 4 2009 ▶ NOV -

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6132 2009 Hosseingholi Nakhaei /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne BUTT Sattimist Medi Cal Curshmetin Glen munde If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3/24/1935 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Min XXXM 2∏ F 74 Director Iran 213-51-1397 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Yes X No Director MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Yarmouth Lane 21114 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married XX Married If Yes, Give Year or Dates: 1 ☐ Yes ZXNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Baltimore, Maryland 2121 Elementary/Secondary (0:12) College (1-4or 5+) 4 Officer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Amirgholi Nakhaei Ghmar Nekovie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sohaila Nakhaei Wife 2402 Yarmouth Lane Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of H important: If ite eny injury or of once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2009 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COVMAN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit The law requires that the death certiticate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signer þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed' 1 Yes 2 No director 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 AInpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of fnjury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending etter death.
I Director: Aff 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ŏ within 24 hours e To the Funeral I 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Mo

31. Date filed (Month, Day, Year) NOV 02

Baltimore

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Leo Bernard Orbach 5:30 A.M October 29, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 615 Hyde Road Silver Spring If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Oct. 10, Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year)}1919 **Funeral** 1 XM 2 ☐ F 90 Months 182-10-5935 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "tw "had coll Expuring in ust be notified at MD Montgomery Silver Spring 1X Yes 2 □ No Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene.
Is marked other than "natural", or items 23a or s 20902 615 Hyde Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Computers Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Orbach Helen Unger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traunonce. Floence Simon Orbach/Wife 615 Hyde Road, Silver Spring,MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Geo, Wash, University
Medical Center 20c. Location - City or Town, State 20a. Method of Disposition October 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2009 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 /M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): FIBRILLATION Examiner 464 Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 2 M No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signature and title of certifier ပ 1 DOU 4/0 72 11.04-200 pot death (Item 23a) (Type, Print) Convecticut Avirue: KGNI ADY 10810. Convecticut 30. Name and address of person who completed cause A2 HAL M 2 - MANIP 31. Date filed (Month, Day, Year) State 04 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Margaret Irene Pate 1:57 am November 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death La Plota Charles Medical Conter | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | FEB 12, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MARYLAND 1 □ M 2 🔀 F 218-24-2989 87 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Charles Port Tobacco 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7991 Terry Drive 20677 U. S. Α. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2∏No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 Vidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 8 Catholic Rectory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Robert Coomes Etta Irene Hart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine B. Logan/Niece 7991 Terry Drive Port Tobacco, MD 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Mem.Grdns. 18,2009 Waldorf, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Raymond Funl. Service, P.A. ne of Funeral Service Licensee Sel M00641 our Banks 5635 Washington Ave., LA Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final NTRA CEREBRAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 2 10 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

/Medical Examiner burial-tran the attending pl P.0. signed t Division of Vital Records, cate has t page 2 sl certificate this After t

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certification: To

29a, Certifier (Check only one)

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

NOV 2 0 2009

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Obgetrinent of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is health and injury or other traumatic event, it is health and injury or other traumatic event, it is health and injury or other traumatic event, it is health and injury or other traumatic event, it is health and injury or other traumatic event, it is health and injury or other traumatic event, it is not the page of the pa

Physician

Baltimore, Maryland 21215-0036

/Medical

State Registrar

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POST OFFICE RD WMDORF MN 20602 ATEL 50 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 37351 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October October 2009 Pass more 6:21 PM M Marion 4a. Facility Name (If not institution, give street and number) 4c. County of Death Prince Georges 4b. City, Town, or Location of Death Laurel Laurel Regional Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 3, Years 22 9. Birthplace (State or Foreign Days Months Hours Min Washington, D.C. 579-08-3535 87 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel Laure1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 USA 3371 Cranberry South 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Synder Amy C. Rigel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3371 Cranberry South Laurel, Maryland 20724 Joan Lewis — Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematery or other place) Date 20c. Location - City or Town, State 11/10/2000 1 TO Burial 2 Tore

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Director

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanine must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, State

	4 Donation 5 Other (Specify))	NUCK CIECK CE	ineter y	11/10/2009	wasimigton	, 10. 20011
	21. Signature of Funeral Service Licens		01783 Fieck 7601	ne and Address of Fa Funeral Hon Sandy Spring	ne, Inc. g Road, Laurel	, Maryland 20	707
	23a. Part 1. Enter the disease, or compl shock, or heart failure (List) only of Immediate Cause (Final disease or condition resulting in death)	a Regn	e death. Do not enter the	mode of dying, such	as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Pre	consequence of): Letter a consequence of): 1 A .				
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death 3 ☐ Ecto	pic pregnancy er (specify)		23d. Date of Month	f delivery Day Year
ted by PI	Part II. Other significant conditions con	ntributing to death but	not resulting in the underly	ing cause given in Pa		. /	te to the cause of death? Probably 4 Unknown
Comple					pe 1 □ Ye	rtopsy prior deat erformed? deat s 2 □ 00 1 □	e autopsy findings available r to completion of cause of h? Yes 2 □ No
	25. Was case referred to medical examiner?	Hospital:		Otheru	ace of Death (Check on	y one)	
၉	To res ZUNO	1 Inpatient	2 ER/Outpatient 3		Nursing Home 5 Re		Specify)
ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, 1	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2		e how injury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, street, fa (Specify)	ctory, office	28f. Location City or	n (Street and Number o Town, State)	r Rural Route Number,
edical	29a, Certifier ft Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of e and manner state	my knowledge, death occu xamination and/or investig d.	urred at the time, date ation, in my opinion, o	e and place, and due to t death occurred at the tin	he cause(s) and manne ne, date and place, and	er as stated. due to the cause(s)
Ž	29b. Signature and title of certifier			29c. License numbe	er	29d. Date signed (M	lonth, Day, Year)
	Karimus	m. r		D687	182	15	1/28/2004

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 19 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 5. Social Security Number 6 SAX Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Year 1 ☐ M 2 🔊 F Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
sair: If items 72 Is marked other than "natural", or Items 23a or 28a-1 show any or other traumatic event, if a headen Earth art mail be notified at ury or other traumatic event, if a headen Earth art mail be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working
 Je. DO NOT use regired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tomemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 umps /aylo 19a. Informant's Name/Relationship (Tyon, Print) 19b. Mailing Address (Street and Number or Jural Route Number, City or Town, State, Zip Code) 7803 C 20b. Place of Disposition (Name of cometery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 □Removal from State Department o Important: If any injury or once. 5 Other (Specify) 4 Donation reinatory tyle of Funeral Cerv 22. Name and Address of Facility Funeral Home 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** emmorr hagic thalamie /Medical Due / (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physiclan/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown à signed I Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has Dertension 2 No of Vital 1 ☐ Yes To the Hospital or Attending Physician: funeral director, Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 2 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury after death.

I Director: After to in by the funera 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral I 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

State Registrar

32. Registrar's Signature

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			For State Registrar	State	of Maryla	nd / Dep. <i>Ce</i>	artmen <i>rtificate</i>			and N	/lental Hy	gier Rea. N	e 20	09	37	353
			Decedent's Name (First, Middle,	Last)							2. Date of De	eath			3. Time o	f Death
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and a	Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, or Location of Death					4c. County of Death				
4			Union Hospita1 5. Social Security Number	•				E1kton If Under 1 Year If Under 24 Hrs. 8, Date				Cecil			(2)	
	Funeral Director		203-24-1969	6. Sex 1 2 M 2 □ F	7. Age (in yr	78 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D May 15	ay, Yea	931	9. Birthp Cour	place (State ntry) Te	xas
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	ocation							1	0d. Inside C	ity Limits
	e Mar	ctor	Maryland Ce	ci1		E1kt	on								1 X Yes	2 🗌 No
	or 28	To Be Completed by Funeral Director	10e. Street and Number				10f. Zip						Citizen of WI	nat Cour	itry?	
	ath w		355 Maloney Rd.					21921					USA			
	item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No					Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.			
215-0036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner rust be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1951-54					1 □Yes 2X No <i>Specify:</i>					Specify: White			
5-0	72 ho 'natur		15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done de					ation 16b.				b. Kind of Business/Industry				
2121	within iene. than		Specify only highest grade completed College (1-4or 5+)							De	Pept. of Commerce					
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it. In "adical Exaria per rough.		17. Father's Name (First, Middle, La	ast)							e (First, Middle		-			
Maryland			John MacKenzi	e Park								nna Ferguson				
Var	12 sho h and 7 is m traum		19a. Informant's Name/Relationshi								al Route Numb			tate, Zip	Code)	
	1 and Health em 27 Ather to		Mabel R. Park/	wire	20h						on, MD		921 Location - C	ity or To	wn State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		State	Place of Dispo cemetery, cre Newark			i						mi, otato	
alti	mit. F portan		21. Signature of Funeral Service		,						nes, Ir		ark,	DE		
ä	permi Depar Impor any ir		p	1			122 V	Foar V. Ma	rd an ain S	d Jo	nes, In Newark,	nc. DE	197	11		
п			23a. Part 1. Enter the disease, or o shock, or heart ailure. List o	omplications that nly one pause on	caused the de each line.	ath. Do not en	ter the mode	e of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximation	tween
and a	Physician		Immediate Cause Final disease or condition resulting in death) a. Lest Cause Final disease or condition resulting in death)					lev	18						Onset and	Death
-	/Medical Examiner		resulting in deathy													
h		I Examiner	Sequentially list conditions, if any, leading to immediate	quence of):												
	eath certificate be executed attending physician and for use as the burial-transit		cause. Enter Underlying Cause (Disease or Injury that initiated events c. AYDS													
50,			resulting in death) Last Due to (or as a consequence of):													
68760	cate b	dica	d													
Вох 6	certif nding ise as	√/Me	IF FEMALE: 23b. Was decedent pregnant		s, outcome of pregnancy						23d. Date of delivery					
B	death e atte	Certification: To Be Completed by Physician/Medical	in the past 12 months? 1 ☐ I've brith 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live brith 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month Day Year			Year			
P.0	at the d by th stache								an in Double 220 Did tohooo							
ds,	signer be d		C) a conditions continuously to death but not resulting in the underlying cause given in Part 1.								o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown					
COL	w requ		CONNAC ANTEN DISTANCE 24a. Was an								24b. Were autopsy findings available					
of Vital Records,	The law te has age 2		TiA	11 6	at				auto _ perfo	prior to completion of cause of death?						
ita	ian: ortifica stor, p		25. Was case referred to medical examiner?		1 □ Yes 2 26. Place of Death (Check only one						7	No 1 Yes 2 No				
<u>></u>	ding Physic n. After this ce funeral direc		1 ☐ Yes 2 No		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury						me 5 Res	6 □Other	6 ☐ Other (Specify)			
ou c			27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Moi							28d. Describe how injury occurred			1		
Division	Attendrated restriction of the		3 Suicide 6 Could no	home, farm, sti	ome, farm, street, factory, office 28f. Locatio				28f. Location (cation (Street and Number or Rural Route Number,						
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn	Certi	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)													
		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										5)			
	To the To the comp									ate signed (Month, Day, Year)						
		Vin Sanuel 033510 Nov 6 2							009							
l	etIVA		30. Name and address of person w	tho completed cau	1 .	em 23a) (Type,	Print)	2 }	o onle	5 P	lata	No	WA	K	De	19702
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 2009	32.1	Registrar's Sign	nature	1		/-				J 17			
	ricgisti	ear.	1107 - 0 2003	Leneus	U p.	gava										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nov. **Physician** 2009 Elsie W. Pierce 6:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗓 F Director 202-18-5529 87 1922 15, New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar roust be notified at Director Maryland Cecil E1kton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Bridgewell Pkwy. 21921 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Completed by Specify. 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant; If item 27 is marked other than 'ury or other traumatic event, Item M. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arley Luff မ Elsie M. Walls 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; if item 27 is any injury or other trau once. Betty Rumme1/Daughter 255 Chandlee Rd., Rising Sun, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 11/12/2009 Elkton, Maryland 21. Signature of Funeral S. rvice Licens 22. Name and Address of Facility $R.T.\ Foard\ and\ Gee$ 259 E. Main St., Elkton, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause inal disease or condition resulting in death) **Physician** *years* /Medical years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): attending physician Be Completed by Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) 9 Unknown 9 Unknown

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certification: To

within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2 s

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown					
						24a. Was an autopsy performed? 1 ☐ Yes 2 █ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No					
25. Was case referre	ed to medical			Check only one)								
examiner? 1 □ Yes 2 🗹 N	lo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation 6 Could not be determined		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe how injury occurred						
3 ☐ Suicide 4 ☐ Homicide		28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												

29c. License number

DO 023322

D

Sachders mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\mathcal{S}.\mathcal{S}$ Acade \mathcal{S} MD, \mathcal{S} Acade \mathcal{S} Thick \mathcal{S} T

Elkton MD 21921.

29d. Date signed (Month, Day, Year)

11.6.2009.

31. Date filed (Month, Day, Year) State NOV 1 0 2009

29b. Signature and title of certification

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Reg. No. Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Vear relka) or other 11 04 2009 1020 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clavert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 86 April 8,1923 Maryland Director 219-12-3098 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Calvert Prince Frederick 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3813 Cassell Blvd. 20678 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic. 12 Administration Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Edward Simms Mary Simms 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Weeks/Son 4200 Van Buren St. University Park,MD 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem.11/6/2009 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any least in the cause of the cause of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-trag Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 2 No 1□ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 257 No 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 X Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 XNo Multiple falls 2009 Unknown M death. To the Hospital or Attenc within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Home Location (Street and Number or Bural Route Number, City or Town, State) **Found: 3813** 4 Homicide Cassell Blvd., Prince Frederick, 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title opcertifier 29d. Date signed (Month, Day, Year) 00061783 MO 2003 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month Day, Year)

2009

32. Begistrar's Signature

100 Hospital Road, Prince Frederick, MD

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \cap \cap Q 37356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 009 Month NOV 5 Glen E. Poorte 6:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 1 **Funeral** 9. Birthplace (State or Foreign 1 🖟 M 2 🗆 F Hours 529 10 7682 Country) Ogden Director 87 1922 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro Maryland Prince George 1 Tes 2 XX 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral 20772 9201 Fairgreen Terrace United States Page 1 and 2 should be filed within 72 hours after death \text{ment of Health and Mental Hygiene.} ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Nes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 Yes 2 TNO Specify Completed 3 Divorced 4 Divorced WWII Specify White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Edward Poorte Lenore (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9201 Fairgreen Terrace, Upper Marloboro, MD 20772 Dorothy Poorte (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory

Lee Funeral Home, Inc 111/6/2009 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final = AIL URE Onset and Death Physician/ CONGESTIVE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to be a cause. Enter Underlying Examine Directo for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) the attending physician a hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 2 🗆 No 4 ☐ Pregnant g ☐ Unknown 1 ☐ Yes ∠ L 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENS 10 N 2 No 3 Probably 4 Unknown 1 Yes DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🔏 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) ည XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation within 24 hours after death To the Funeral Director: ocmpleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

BB | U | State

31. Date filed (Month, Day, Year)

NOV 0 6 2009

30. Name and address of person who completed cause NELSON BENJEL

completed cause of death (Item 23a) (Type, Print)

JERS , 813 PIS CAT AWAY & CLINTON, MD 2073.5

2009 Seven A. Januar

Registrar

28281

05

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 2009 Benicia Reyes 8:30 PMM /Medical 4a. Facility Name (If not institution, give street and number) -4b. City, Town, 6r Location of Death 4c. County of Death Examiner 3404 Oakhurst Drive Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1918 9. Birthplace (State or Foreign Country)
El Salvador **Funeral** 1 □ M 2 Ϊ XF Months Days Hours Min 91 Sept. **Director** 553-93-6234 Usual Residence of Decedent 10b. County show. 10a. State 10c City Town or Location 10d. Inside City Limits 23a or 28a-f show Director 1 X Yes 2 □ No 28a-f Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Oakhurst Drive 20866 El Salvador Funeral or items, permit. Pages 1 and 2 should be filed within 72 hours after det Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items any injury or other traumatic event, the Medical Event 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1√2 Yes 2 □ No ģ Specify: Specify: Hispanic 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vicente Reyes Antonia Reves ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3404 Oakhurst Drive, Burtonsville, Maryland 20866 Santos Paula Reves - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anamoros Cemetery 11/16/2009 Anamoros City, El Savador 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signature of Juneral Service Licens 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heeme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner a Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last burial Due to (or as a consequence of) physician at the burial Completed by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 1 ☐ Yes 2 NO 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this neral Director; After the filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manno of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier

The law requires that the death certificate be executed Box 68760, P.O. I Records, of Vital Hospital or Attending Physician: Division To the Hospital c within 24 hours af To the Funeral C completely

Maryland 21215-0036

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darryl A. Hill, M.D. 13635 Baltimore Avenue, Laurel, Maryland 20707

NOV 02 2009

29b. Signature and title

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

29c. License number

7235

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** race J. Kandolph /Medical 4a. Facility Name (If not institution, give street/and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2178 Sykesuile 7100 BrochtRd arrol If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 79 July Director 159-26-9095 3, 1930 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 710 Obrecht Road, Room E-22 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal & State Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer & Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Cyril Dewey Jensen Bessie Hilda Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond E. Randolph/Son 52 Henry Drive, New Providence, PA 17560 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Nov. 4 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dementic terminal loyers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical SE IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 ☐ Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s 2 - NO Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? I Director; After to in by the funeral Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Nicholas Hozama D00062791 11/4/09 Nicholas A. Kozaner, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 21784

Sykesville, MD

22. Registrar's Signature

Object Rd

710

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month /Medical Frances M. Ronn November 3, 2009 4:20 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1716 Forest Glen Drive Prince Frederick Calvert Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Days Hours Min. Director 84 PA 148-18-2703 November 3, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rral", or items 23a or 28a-f sh Evaniner must be notified 1 ☐ Yes 2 KNo Directo MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1716 Forest Glen Drive 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> Specify: Specify. 3 Midowed 4 □ Divorced "natural" White Completed 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 School Teacher's Assistant Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William J. Burns Frances M. Yonker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra 1716 Forest Glen Drive, Prince Frederick, MD 20678

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State William Ronn - son 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gloucester Co. Veterans Cemetery November 7, 2009 | Monroe Township, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Blades a. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exam attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO Hospital: 1 ☐ Yes 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending of Funeral Director: Affiletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date sigged (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name and a tho completed cause of death (Item 23a) (Type, Print) dRW 31. Date filed (Month, Day, 32. Registr Year. State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37360 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year AKE NOVIMBU 1031 AM 209 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Baltimore** to +Mar 2 If Under Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
7 22 1961 Birthplace (State or Foreign Country) Social Security Number 7. Age 1∏M 2☐F Hours Months Days Min

10f. Zip Code

21782

1 ☐ Yes 2 🖔 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Waynesboro, PA

white

10g. Citizen of What Country?

14. Race - American Indian.

Black, White, etc

US

Specify:

10d. Inside City Limits

1X Yes 2 □ No

48

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

10c. City, Town or Location

Sharpsburg

72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Evandure is ust be notified at once. Baltimore, Maryland 21215-0036

1 - State Registra

10a. State

MD

Director

Funeral

þ

Be Completed

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208-50-5468

Usual Residence of Decedent

1 Never Married 2 Married

3 Widowed 4 Divorced

10e. Street and Number

11. Marital Status

10b. County

17030 Tow Path Lane

Washington

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical **Examiner**

attending physician and for use as the burial-tran cate has t certificate

Examiner Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. Be Certification: To Medical 15

Division of Vital Records, P.O. Box 68760,

15. Decedent's Edi (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Decedent's (Give kind of life. DO No	16	16b. Kind of Business/Industry							
Elementary/Secondary (0-12)	College (1-4or 5+)	recei	wheel mfg.								
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)									
David Stahl			Phy	711is V	Vingert						
19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailing Add	dress (Street and Num	ber or Rural F	Route Number, C	City or Town, Sta	te, Zip Cod	e)			
Wanda Stahl			ow Path Lar		arpsburg		1782_				
20a. Method of Disposition 1 Description 2 □ Cremation 3 December 4 □ Donation 5 □ Other (Specify	nemoval nom state	ace of Disposition (Name of metery, crematory or other place) nk's Church Cem. Date 20c. Location - City or Town, State Antrim Twp. 11/16/2009 Franklin Co., PA									
21. Signature of Funeral Service Licens	ulossa		22. Name and Address of Facility Miller-Bowersox Funeral Home 521 S. Washington St. Greencastle, PA 17225								
23a. Part . Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused the deat one cause on each line.	h. Do not enter the	mode of dying, such a	s cardiac or r	respiratory arrest		App Inte Ons	roximate rval Between set and Death			
disease or condition resulting in death)	a. Due t) (or as conseq	uence of):	Durage								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):	riuurica								
that initiated events resulting in death) Last	c Due to (or as a consequence of): d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	aldeath 3 Ecto	pic pregnancy er (specify)			23d. Date of Month	delivery Day	Year			
Part II. Other significant conditions co	ontributing to death but not res	ulting in the underly	ing cause given in Parl	l.		cco use contribut					
					24a. Was an autopsy performe	d? prior	to complet	indings available tion of cause of No			
25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: 1 npatient 2	ER/Outpatient 3			Check only one) 5 Residence	ce 6 Other	Specify)				
27. Manner of Death 1		28b. Time of Injury M			d. Describe how	cribe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa fy)	e, farm, street, factory, office 28f. Loci City			ocation (Street and Number or Rural Route Number, ity or Town, State)					
	ysician: To the best of my kno niner: On the basis of examina and manner stated.										
29b. Signature and title of certifier		29c. License number 29				d. Date signed (Month, Day, Year)					
Cath	, ∧	1.D.	181-	19		Nov 12	1,20	09			
30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)									

State Registrar atherine Smith, NOV 2 0 2009

22 S. Greene St., Baltimore, MD 21201

Registrar

934 S

SETON DR. CUMBERUNO, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POOMI M.D. C. 32. Registrar's Signature

			For State	State of M	larylan		artment of F						0.70
			Registrar 1. Decedent's Name (First, Middle	Local		Cei	rtificate of	Death			eg. No. 2 ()	09	37362
н	Physici		11 Decedent a Ivanie (1 II st., Iviidan			0. 1				2. Date of Dea Month	Day	Year	3. Time of Death
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			Renaissance		,			ilver S			'	e Geo	raola
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under Hours	***	8. Date of Birth (Month, Day		g. Birthp	lace (State or Foreign
	Director		291-09-2153	1図M 2□F	92	Yrs.	World Days	Hours		eptember		Cour	Ohio
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	cation					1	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number	gomery	<u> </u>		10f. Zip Code	lver Sp	oring	1	0g. Citizen of W	hat Coun	
	th with		3114 Gracefield	I Road. #205				2090	1 /1		3		•
	ems :	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Vas Decedent of H fYes, specify Cuba			cify Yes or No-			an Indian,
36	or it	by Fu	1 Never Married 2 Marr	ed 1⊠Yes 2□ If Yes, Give			☐Yes 2KINo	Specify:		ican, etc.)		, White, e	etc.
5-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show a Madical Evan har nust be notified at		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WWII						Specify:	Afric	an-American
Ç	in 72 n "na	plet	15. Decedent	t grade completed)		(Give i	lent's Usual Occup: kind of work done o OO NOT use retired	lurina mosi	t of working	7	16b. Kind of Bus	siness/Inc	lustry
717		Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		Social		•		Go	vernme	ent
_	~ = 0 9	Be C	17. Father's Name (First, Middle,	ast)				18. Mothe	er's Name (First, Middle, N	Maiden Surname		
<u>Va</u>	2 should be f and Mental is marked or raumatic eve	T0	Robert Ke	nneth Stephens	3				Mi1	dred Are	na Napper		
Maryland	2 sho		19a. Informant's Name/Relations	,		19b. Mailin	g Address (Street a	and Numbe	er or Rural	Route Number	City or Town, S	State, Zip	Code)
e,	is 1 and 2 of Health a Item 27 is other trai		Dorothy Stephens - 20a. Method of Disposition	Spouse	Look Di		Gracefield	Road,					
و	ages int of t: If Ite		1 ☑ Burial 2 ☐ Cremation		CE	emetery, cřem	sition (Name of atory or other place	e)	Da	te :	20c. Location - (City or To	wn, State
aitimor	nit. Py artme ortani Injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signatu/e Funeral Service I		Fort	_	n Cemetery Name and Addres	-	1/07/2	009	Brentwood	, Mary	yland
n	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic e once.	0 9	Vielolor	1/241/0	MAND I	. / H:	ines-Rinald 1800 New Ha	i Fune	ral Ho	me, Inc.	on Couinc	M7	1 2000/
			23a. Part 1. Enter the disease, or	complications that cause	d the death							, mary	
×.F	Physician	4	shock, or heart failure. List of Immediate Cause (Final disease or condition			Approximate Interval Between Onset and Death							
	/Medical		resulting in death)	a. G. I. Due to (or as		ence of):						-	4 Days
	Examiner	L	Sequentially list conditions, if any, leading to immediate			phagia S	S/P peg						2 Years
	ted sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):							
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0/00,	or activities by secarificate be executed that death certificate be executed black death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	-	d Dement		·							
0	ng phr as th	Nedi	IE EELIN E										
Š	attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date		у
5	by the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)				Mont	th [Day Year
	ed by detac		Part II. Other significant condition	s contributing to death b	ut not resul	lting in the un	terlying cause give	n in Part I		23e Did tob	and use contrib	uito to the	e cause of death?
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Spins	s been sig should be	Completed		-					- 0	24a. Was an			
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ן מ	certificate rector, pag	0	25. Was case referred to medical					26 Place	of Death //	1 □Yes 2 Check only one	K No 1	□Yes 2	2 🗆 No
> 3	nysic nis ce direc	<u>ම</u>	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	R/Outpatient	Otho				nce 6 ☐Other	(Specify)	
	After th	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y, Year)	28b. Time of Injury	28c. Injury Work	at			v injury occurred		
מיל מיל	tor: A	cati	2 Accident investigation in a suicide 8 Could no	at he	5.6	-0.	M 1 □ Y	es 2 🗆 N	10				
	after of Direction by	Certification:	4 ☐ Homicide determin		ury - At hon c. <i>(Specify)</i>	ne, farm, stree	et, factory, office		281	Location (Str. City or Town,	eet and Number State)	or Rural	Route Number,
l lotica	ours and and and and and and and and and and		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my know	ledge death	occurred at the tim	e date and	d place, an	d due to the co	uso(s) and man	nor on other	
, T	To the Function of Architel Within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	Check only Z Medical E	xaminer: On the basis o Practardmenmer sta	t examinati	on and/or inve	estigation, in my op	inion, deat	th occurred	at the time, da	te and place, an	d due to t	he cause(s)
Ę	withii To th	ğ	29b. Signature and title of certifier				29c. License	number		29	d. Date signed (Month, D	ay, Year)
	(ot)		Kathenie	D. Jante	76 C	RNP	RIZ	168	30		11/2/0	9	
	- '		30. Name and address of person w				,						
	Stat		Kathy D. Jantac, 31. Date filed (Month, Day, Year)	32 Begistre	ar'e Signatu	IFO.		ing, M	arylan	d 20904			
	Registra	-	NOV 04 2	009 Service	A.	par	Les.						

			For State	State o	f Maryland		artment of H <i>tificate of D</i>		and M					
			Registrar 1. Decedent's Name (First, Midd.	ie, Last)		Cer	lilicate of L	eaur		2. Date of Dea		ath 3 Time of Death		
1	Physicia			Young K	i Shin				- 1	Month November	Day	2009	10:15p _M	
	Medic Examin		4a. Facility Name (if not institution		ber)		4b. City, Town, or	vn, or Location of Death 4c. County of Deat			unty of Deatl	า		
				sworthy Road				th Poto				Montg		
	Funeral Director		5. Social Security Number 061-60-9328	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Bird (Month, Da October	th y, Year) 29, 193	9. Birt Coι	hplace (State or Foreign intry) Korea	
Б	Jow at	ايا	Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Loc	cation						10d. Inside City Limits	
arylar	a-fsh fieda	Director		ntgomery		,		h Potor	mac				1 ☐ Yes 2 基 No	
the M	or 28:	۵	Maryland Mo 10e. Street and Number	inegomery			10f. Zip Code	11 1000			10g. Citizer	of What Co	untry?	
with	s 23a ust b	Funeral	12931 Eswo	rthy Road				20878				U.S.A		
ISING Z1Z13-UUSO be filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	11. Marital Status 1 ☐ Never Married 2 🗷 Ma	Armed For	2 🗷 No	If	Vas Decedent of His Yes, specify Cubar	n, Mexican,	in? (Spec , Puerto R	ify Yes or No- ican, etc.)		Race - Amer Black, White	, etc.	
2-00.2 hours aff	tural", al Exa		3 Widowed 4 Divorce	Tear of Ba			☐ Yes 2 🗷 No				Spe	ecify:	Asian	
72 ho	n "na' ledica	Completed	(Specify only high	ent's Education lest grade completed)		16a. Deced (Give k	of workin	g	16b. Kind	of Business I	ndustry			
vithin	h and Mental Hygiene. 7 is marked other than "; traumatic event, the Med		Elementary/Seconday (0-12)	College (1-	4 or 5+)		NOT use retired) Assembler					Commun	ications	
filed v	al Hyg I othe Vent,	Be	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name	(First, Middle,	Maiden Sun	name)		
yland Id be filed	Menta arked atic e	욘	Yun	Hak Chung			Eun Im Cho							
Mar. 2 shou	raum			9a. Informant's Name/Relationship (Type, Print)			•			l Route Number, City or Town, Sta				
e, n	Health tem 27		David UK Shin - 20a. Method of Disposition	Son	20h Pi		Esworthy R	oad, No		Potomac,		nd 2087		
nor age 1	ant of h		1 🗷 Burial 2 □ Cremation 4 □ Donation 5 □ Other		State C6	ernetery, crem	natory or other place	1 1	L 1/06/					
Saltimol permit. Page 1	Department of Healtl Important; If item 2 any injury or other tonce.		21. Signature of Pinera Service	- / 11 / 1	MALI	22 H	orial Park . Name and Addres ines-Rinald	s of Facility	ral Ho	ome. Inc		y, Maryl		
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	vsician/		Immediate Cause (Final disease or condition			ncer of	Kidney to	Liver a	and L	ıng			Onset and Death	
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ate be executed	physician and s the burial-transit	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	c	ence of):									
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s, F.C.	igned by be detac	þ	Part II. Other significant condit	tions contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.					the cause of death?	
rds requir	should	etec								24a. Was			opsy findings available	
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or C	ath. :: After e fune	icate	1 X Natural 5 Pend 2 Accident Inves	ling (Moniting tigation	h, Day, Year)	injury	work'	? Yes 2 □ !			,,			
DIVISION OT tal or Attending PI	after des Director d in by th	Certificate:	3 Suicide 6 Coul 4 Homicide deter	minod 28e. Place	of Injury - At ho		eet, factory, office		2	8f. Location (9 City or Tow	Street and No In, State)	umber or Rur	al Route Number,	
L Hospita	within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	(Check 2 Medical	ng Physician: To the b Examiner: On the bas ng Nurse Practioner:	is of examination	and/or invest	tigation, in my opinio	n, death occ	curred at t	he time, date a	ind place, and	d due to the c	ause(s) and manner stated.	
To th	To the	2	29b. Signature and title of certific		MA	uh	29c. License					igned (Month		
	4		30. Name and address of person				Print)					<u>U</u>		
	Sta	to	Daniel I. Kim, 31. Date filed (Month, Day, Year)	2 . R				ryland	2085	2				
	Registr		NOV 05	2009 Cen	egistrar's Signa	par	Par .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ruth Virginia Day Year Scho1z 2000 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Agnes HOSDita Baltimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 1 F 218-28-0200 88 Oct 17 1921 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 Benson Avenue #321 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Scott Edna Derr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Stansbury (daughter) 1572 Ella Lane, Stem, NC 27581 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 11-9-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Harght Serbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent e of): days Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events atria tibillatio resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1 □Yes 2 ANO 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

and attending physician a for use as the burial-Box 68760, P.O. cate has been signed by the a page 2 should be detached in Vital Records, Scholz certificate has Physician: funeral director, Division of After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Physician/Medical à Completed Be Certification: To

Examiner

Physician

/Medical

10a. State

Director

Completed by Funeral

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Examiner

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Director

or than "natural", or Items 23a or 28a-f share Mcdical Evan instrust be notified

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Evaluates 23a apprecia

Physician

/Medical **Examiner**

Baltimore, Maryland 21215-0036

the Maryland

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

MO

1058571

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Tao MD yun 32. Registrar's Signature 31. Date filed /Month

Avenue Baltimore

manyland

State Registrar

Medical

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Barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Edith C. Saroli-Silva November 02 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL SALISBURY KICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 M 2 XF Months Days Hours 137-58-0286 Yrs. 12/21/1951 Peru Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 405 Nomreh Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1**K**Yes 2□No Specify: Peruvian 3 Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) counselor domestic abuse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Saroli Ricardina Abad 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariella Rodriguez/daughter 31 Dollard Dr., North Babylon, NY 11703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Salisbury Crematory 11/7/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Lio 22 Horrad Address Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Cancer disease or condition resulting in death) Due to (or as a consequence of): Sensos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Multi organ faiture Due to (or as a consequence of) d. Date of delivery Month Day Year contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Certification:

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medical Evaning in unit by multibut at

Hygiene.

2 should be fill and Mental F

other

Department of Important: If it any Injury or concess

Pages 1 and 2: of Health a

permit.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ng physician and as the burial-tran. attending physician signed by the a d be detached for this certificate has been al director, page 2 should After thi Funeral Director; stely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of deliver Month		
Part II. Other significant conditions	s contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute to the
			24a. Was an autopsy performed? death? 1 □ Yes 2 □ No 1 □ Yes 2
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outp	oatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence 6 Other (Specify)
27 Manner of Death	28a Date of Injury 28h Tir		201.5

4 Homicide 29a. Certifier

5 Pending investigation 6 Could not be determined

(Month, Day, Year)

Injury

Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

1 Natural

2 Accident

3 Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 068222

29d. Date signed (Month, Day, Year) 03/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MAZA M.D. AFZAL 5

29b. Signature and title of certifier

E. CA 1/011 100 32. Recistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

SALISOUN, MO

State Registrar

within 24 hours a To the Funeral I

09-08359 Daniel Chris	stopho		Please Type or Print in Black Indelible Ink hroop State of Maryland / Department of H For State Certificate of D	ealth and Mental H		ible. 2009 3736						
Phy	sicia		Registrar 1. Decedent's Name (First, Middle,Last)	eairi	2. Date of Death							
Medical Ex		ner	Daniel Christopher Throop		Month October 28							
				City, Town, or Location of Death aurel		4c. County of Death Prince George's						
Fune Direc			215_15_896/ X	f Under 1 Year If Under 24Hrs Months Days Hours Min		9. Birthplace (State or Poreign Pennsylvania						
		L	Usual Residence of Decedent		Aprii	22,1907 Teaming y I valida						
pu .	show any		10a. State Maryland Prince George's Laurel			10d. Inside City Limits 1 X Yes 2 No						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	sa or 28a-f stified at or	Dire	10e. Street and Number 12803 Fernwood Turn	of. Zip Code 20708	10	log. Citizen of What Country? United States						
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hours a	natura Examir	ed by	during most	Usual Occupation (Give kind of of working life. DO NOT use ret	work done red)	16b. Kind of Business/Industry						
)36 thin 72	than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unemp1			none						
5-00 iled wii Hygier	the M		17. Father's Name (First, Middle, Last) Carl Anthony Throop	18.Mother's Name								
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MD 12 shot	umatic			ndian Trail,#1		r Heights, TX 76548						
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Bal perm Depa	in in		finale UB nwood 440	ald V. Borgward Powder Mill I	lt Funer. Road Bel	al Home, PA tsville. Marvland 2070						
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, xami		İ	Immediate Cause (Final disease or condition resulting in death) a. Complications of Intestinal volvulus Due to (or as a consequence of):									
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ox 68 ath cert	attendin or use a	sicia	past 12 months? 4 Pregnant at time of death 5 Other	(Specify)								
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Reco	icate ha	WOS			perfor 1 ✓ Yes 2							
ital Sician:	irector,	a	25. Was case referred to medical examiner? 1 ✓ Ves 2 No. Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3	26.Place of Death (Check		Residence 6 Other:						
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sion Attendii death.	y the fu	atio	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.	To the Funeral Director: After this certificate be completely filled in by the funeral director, page	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, (Specify)	actory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Number, City late)						
the Hos hin 24 hc	the Fun	dical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner:On the basis of examination and/or investigation	at the time, date and place, and, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)						
To Tim	ř S	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)						
3			unesc.	O.C.M.E.		October 31, 2009						

State Registrar

3. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year) NOV 0 5 2009

	ŀ	For State Registrar	Please	State of M		d / Depa		Health and M	-		_	37367
Physicia		1. Decedent's Name	e (First, Middle, L	ast)		Taylo	r		2. Date of De Month		Year 2009	3. Time of Death 1:15 A M
/Medic Examin			f not institution, g	ive street and numbe	r)	14910		r Location of Death			nty of Death	1.13 A
LXaIIIII	CI	8100 Cor	nnecticui	t Avenue	e #1424 Chevy Ch			hase		Mon	tgomer	У
Funeral		5. Social Security N		Sex 7. A	ge (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birthp	place (State or Foreign
Director		132-09-54	439	1□M 2)(∏ F	89	Yrs.	Willia Days	Tiours Will.	Nov. 21			
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23a or	Funeral Di			Ave., #14	124		2081			United	State	S
tems		11. Marital Status		12. Was Deceder Armed Forces	?	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.))- 14. F	Race - Americ Black, White,	
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hour tural	To Be Completed b	3 M Midowed	15. Decedent's E			16a Dece	dent's Usual Occup	pation		16b. Kind o	f Business/Inc	
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d be filed ental Hyg ced othe c event,		17. Father's Name (First, Middle, Last) Samuel Ifshin 18. Mother's Name (First, Middle, Maiden Surre Bessie Kopman							name)			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and be notified at once.		19a. Informant's Na Barbara I					•	and Number or Ru uare, Cha			wn, State, Zip 02129	,
ages 1 ar ent of Hea nt: If item y or othe		20a. Method of Disp		Removal from Stat	e		sition (Name of matory or other place	metery 11	Date /02/00		awn, L	
Department Popularian May injur		21. Signature of Fu			OLOO		Name and Address	ky Hebrew	Funera	1 Home		
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The law cate has I page 2 s	Completed				<u>-</u>				24a. Was auto perfo 1 □ Yes		prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
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ending F sath. or: After he funer	ation	27. Manner of Deat 1 X Natural 2 Accident	5 ☐ Pending investigati	ion	Da <i>y, Year)</i>	28b, Time o Injury	Wor	ryat rk?]Yes 2□No	28d. Describe	now injury oc	currea	
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		Leanne J	ress of person wh	o completed cause of 1.D., 6715	death (lter	tier Av	ve., #100	, McLean	, VA 2	2101		
Sta Registi		31. Date filed (Mon	oth, Day, Year)	32. Regi	strar's Signa	ature As an	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death PILLIE Year 09 ILOR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake House Hospice Harwood Anne Arundel 8. Date of Birth (Month, Day, Year Dec. 12, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2**/**F Days Year) Hours Min. 217-46-7165 62 Yrs Wash. DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Prince George's Suitland 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4850 Huron Avenue 20746 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Manager Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward B. Klug Audrev Caldwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William O. Taylor, Jr. (husband 4850 Huron Avenue Suitland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Nov. 8, 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Clinton, MD 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate

Physician /Medical Examiner

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

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MD

Director

Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examinationals he notified at

permit. Pages 1 and 2 s
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Baltimore, Maryland 21215-0036

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FEMALE: b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year					
t II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow					
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No					
Was case referred to medical examiner?		Death (Check only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursi	ng Home 5 ☐ Residence 6 ☐ Other (Specify)					
Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? □ M □ □ Yes 2 □ No	28d. Describe how injury occurred					
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		- I inpatient E	Livoupatient 3	DOA 4 LI Nursing F	some 5∟IHe	sidence 6 Tyther (Spe	city) #105016E		
27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
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29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and	title of certifier			29c. License number		29d Date signed (Month	h Day Voorl		

State Registrar 31. Date filed (Month, Day, Year) 32. Registra s Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

n 24 hours after death.

e Funeral Director: A pletely filled in by the fu

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 4, 2009 Lewis Vest Sr. 2:35 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5645 Thrice Place Charles County Waldorf If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/26/1933 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 228-38-1466 76 Virginia **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director MD. Charles County Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5645 Thrice Place 20602 United States death v Funeral filed within 72 hours after deal I Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Excavating permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vest Harley Irene Yates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Vest / Wife PO Box 544 Bryantown, MD. 20617 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Trinity Memorial 11/09/2009 Waldorf, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig + y re of Funeral Service Licen-22. Name and Address of Facility Huntt Funeral Home 3035 01d Washington rdn 20601
enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chrone **Physician** 061 /Medical Due to (or as a consequence of) Examiner Kestrutive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and Due to (or as a consequence of) burial-1 Box 68760, the attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Month Day Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Division 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 □Yes 2 □No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) any manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0033426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 LAGRANGE AVE, LAPLATA, MD 20646 JENKINS MD 31 Date filed (Month. 32. Registrar's Signature State 6 2009 Registrar

			For State	State of N	Marylan		artment of F tificate of L		and M	•	_	nna	37370	ì
			Registrar 1. Decedent's Name (First, Middle	, Last)		00,	inicate of L	Jean		2. Date of De		000	3. Time of Death	
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	with the	Funeral Director	10e. Street and Number 6441 Jefferson	Pike			10f. Zip Code 217	'03			_	en of What Coi SA	untry?	
	je 1 and 2 should be filed within 72 hours after death with the Manyland tof Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status	12. Was Deceden			/as Decedent of H Yes, specify Cuba	ispanic Ori	igin? (Spec	ify Yes or No-		1. Race - Amer		_
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Baltimore, Maryland 21215-0036	. Page 1 tment of tant: If it jury or o		1 Burial 2 X Cremation 4 Donation 5 Other (S			thsbur	g Cremat	ory 1			Smith	nsburg,	Maryland	
Ball	permit. Page 1 Department of Important: If it any injury or o	į, į	21. Signature of Euneral Service	icens) MO11	.76 10	Name and Addres	ss of Facilit hurch	y Keer n Stre	ney & Free	Basfor ederic	ed P.A. ek, MD	F.H. 21 7 01	
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J o	ng Phy ter this neral d	te: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of in	ijury	ER/Outpatient 28b. Time of injury	28c. Injury	4 <u> </u>		e 5 L. Resid d. Describe h		Other (Specificourred	y)	-
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Division of Vital Records, P.O. Box 687	al or Al s after I Direct d in by		4 ☐ Homicide determi		etc. (Specify)		et, factory, office		28	If. Location (S City or Town		umber or Rura	l Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or investig	gation, in my opinio	n, death oc	curred at the	ie time, date ai	nd place, an	nd due to the ca	use(s) and manner stated.	i.
	To the Comp	2	29b. Signature and title of certifier		le Beet et tilly	mornoage, ac	29c. License		and place,			signed (Month,		1
	_		· Vu	MD			D60	417	7		11-1	13-04	3	
	5		30. Name and address of person v		death (Item		mas To	har	\sim	Dr	Twa	devin	21702 EK MD	
	Stat		31. Date filed (Month, Day, Year)	A.Y	trar's Signatu		9	MILL		21	1 4 5	51 (V) C	- F- (1)	1
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ Whitten 2009 Darlene 6:55 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10401 Procter Street Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days June 15, 1 🗆 M 2 🎛 F Hours Min 1926 Director 476-14-0043 83 Minnesota Usual Residence of Deceden 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Maryland Silver Spring Montgomery 1 🗌 Yes 2 🏝 No ᅙ 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 10401 Procter Street 20901 IISA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White Completed 3 KN Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accountant CPA Firm it. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other t njury or other traumatic event, <u>th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Karl Drinkwitz Ida Miller 19a. Informant's Name/Relationship (Type, Print) - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Kristine Whitten-Peterson 10401 Procter Street, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State Nov. 6 2009 Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signal re If Funeral Service Licen 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Cause (Disease of in jury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death the detached Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Non-Hodgkins Lymphoma 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has page 2 death? 1 ☐ Yes 2 ☐ No Division of Vital ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other 1 Yes 2 **X X**No 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate; 28d, Describe how injury occurred work? Natural (Month, Day, Year) injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital
within 24 hours a
To the Funeral C
completed filled Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) W D35635 November 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 18111 Prince Philip Drive, Olney, MD 20832 Joseph Kaplan, 31. Date filed (Month, Day State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () () 9 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 2, 2009 Whitesell Janice Newton 3:20 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 411 Firestone Drive 8. Date of Birth

(Month, Day, Year)

June 17, 1952 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral Days 1 □ M 2 🏝 F Months Hours 57 Washington, 578-72-2212 Director Heual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 USA 411 Firestone Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 XNo If Yes, Give Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 4 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Savella Lee Stuart James Marshall Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Firestone Drive, Silver Spring, MD 20905 Jeffrey Lee Whitesell/Husband 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 6, cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2009 Alexandria, Virginia 22 Name and Address of Collina Funeral Home Inc. Francis 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death

3 years Immediate Cause (Final Physician Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 anding purchase to IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months? Month Day Year 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death the g 🗌 Unknown signed by the P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician; The law requires 24 hours after death. 2 →No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Division of Vital Records, cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 2 🗆 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\mathbb{N} \) Residence \(6 \) Other (Specify) 1 🗌 Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending ours after death. neral Director: Aft filled in by the fur 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer 29c. License number

Registrar

State

30. Name and address of person Paul Thambi,
31. Date filed (Month, Day, Year)

NOV 04

140

D61083

Modical Center Drive, #300, Rockville, MD 20850

2009

State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#4c, perMD&10b, perFH, 11/12/09, per Settificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 31, 2009 A M 7:10 Weil Joan Patricia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Silver Spring Riderwood Montgomery 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F Hours New Zealand 94 074-38-9089 Director Usual Residence of Decedent 10a. State 10b. CountPrince George 10s. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, If a Medical Examinat near cultical at Silver Spring MD Montgomery Yes 2 □ No Director 10e. Street and Number 3152 Gracefield Road MS-103 10f. Zip Code 20904 10g. Citizen of What Country? United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify Specify: ⋧ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur L. Bayliss Olive Boys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7617 Takoma Ave. Takoma Park, MD 20912 Richard D. Weil / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 11/05/2009 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fundral Service 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 9 icate has been si , page 2 should t. 1 🗌 Yes 2 ANo 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 11/02/2009 D24093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Parkhurst MD 3110 Gracefield Road Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 04 Registrar

Registrar DHMH 17 Rev 1/2001

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/MEND#20bperFH, 11/5/09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 31. 2009 Bert L. Walls October 2:50 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 10813 Green Valley Road Union Bridge 8. Date of Birth (Month, Day, Year) Nov. 13, 1916 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Days 1X M 2 | I Hours North Carolina Director Yrs. 238-01-1870 92 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎦 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2807 Munson Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4 Divorced WWII Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha the Supervisor Verizon Telephone Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bert L. Walls Mamie Coates Drye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Munson Street, Wheaton, MD 20902 Elizabeth Guthridge Walls/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o
once. Nov. 2009 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service License Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, esessit. MO1503 MD 20901 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death sbock, or heart failure. List only one cause on each line Immediate Cause (Final Coronary Artery Disease Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or imjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) raughter's Other: 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar DHMH 17 Rev 7/2009

State

3

Signature and title of certifier

31. Date filed (Month, Day, Year)

Kevin Brewster, D.O.

04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

only one)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Kings Drive, Taneytown, MD 21787

H55845

29d. Date signed (Month, Day, Year)
November 2,

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 26. 2009 11:34 PM Margo Emily Wirig Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign Country) Canada If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 8/25/1947 1 M 2 TXF Months 227-74-6881 62 Director Usual Residence of Decedent 3a or 28a-f show be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State within 72 hours after death with the Maryland Director Anne Arundel Annapolis Maryland 1 Yes 2 🗌 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ms 23a Funeral USA 21403 710 Americana Drive #58 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the TKF Foundation Personal Assistant ith and Mental Hygien 27 is marked other the r traumatic event, the Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ be f Helen Rogers Robert Kervin permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Americana Dr., Annapolis, MD 21403 Marc Wirig - Husband 20b. Place of Disposition (Name of 20a, Method of Disposition 20c Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/28/2009 Baltimore, MD Baltimore Crematory 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myclin 147 Duke of Gloucester St, Annapolis, MD21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death been signed by the should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗆 No M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009 Signature a

RIVARD, Stell2

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Todd Dwight Wheeler, Sr. 2009 37377 Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 9, 2009 1115 hrs Medical Examiner Todd Dwight Wheeler, Sr. 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Howard County General Hospital Columbia Howard 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** 5. Social Security Number Age (In yrs. last birthday) Months Days Hours Min. 213-84-2416 Director 46 11/8/1963 Country) 1X M 2 Md Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Md. Baltimore 1 Yes 2 X No is 23a or 28a-f show e notified at once. 28a-f show Upperco . Pages 1 and 2 should be filed within 72 hours after death with the Maryland innent of Health and Mantal Hygiene.

The filed file and 21 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e, Street and Number 10f, Zip Code 15240 Parrish Road 21155 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 XYes 2 No 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2X No specify: Specify: white 1981 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 welder welding 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emmett B. Wheeler, Jr. Wynema Folev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Yvonne D. Wheeler, sife wife 15240 Parrish Road, Upperco, Md. 21155 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date **Baltimore**, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: Paul's Cemetery 11/14/2009 Arcadia, Maryland St. Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M00741 South Main Street, Hampstead, Md emmer Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) mitral valve prolapse Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Item 19a per F.D. 11/16/09 Carrol1 line a-b,27.permE, g898 12/21/09 X UNPENDED X AMENDED attending physician or use as the burial Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? ✔ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred fication: To the Hospital or within 24 hours after death.

To the Funeral Director: A X_{Natural} 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 평 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL O.C.M.F. November 10, 2009 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Regintrar's Signature State Registra

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Physician	
/Medical	
Examiner	

Funera

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once. **Physician**

/Medical

Pt Known as Wed! A.H. Agui Baltimore, Maryland 21215-0036

Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar	Certificate of Death Reg. No.
	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
ian cal	Wali A.H.	Aquil November 17 2009 12:24AM
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	Sinci Hospital of Beltimo	nove Baltimore City
	5. Social Security Number 6. Sex 7. Age (In yrs. I	
	Usual Residence of Decedent	
tor	10a. State 10b. County 10c. City NA	ity, Town or Location 10d. Inside City Limits Baltimore 1√√Yes 2□No
rec	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
Funeral Director	4214 Fernhill Ave	21215 U.S.A.
nue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
by Fi	1 ☐ Never Married 3 ☐ Married 1 ☐ ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2½ No Specify: Specify: Black
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The property of the
E	Elementary/Secondary (0-12) College (1-4or 5+) na	Salesman Commissary
Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
To B	Vanroe Clanton	Elizabeth
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	L. Shahidah Aquil-Wife	4214 Fernhill Ave, Baltimore, Md 21215
		Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ki	ing Memorial Park 11/18/2009 Woodlawn, Md
Ш	21. Sign with of Funeral Service Licensee	22. Name and Address of Facility March F/H West
	Verome U. Ihm pear	✓ 4300 Wabash Ave, Baltimore, Md 21215
	23a. Part 1. F ter the disease, or complications that caused the death shock, it heart failure. List only one cause on each line.	th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Immediate Jayse (Final disease or c vidition	ry embolism 7 days
	resulting in death) Due to (or as a consequ	
L	Sequentially list conditions, b. COPD (C	Chrome Obstructive Philmonary Discose) 10 years
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Contraction
xar	that initiated events resulting in death) Last C. Due to (or as a consequence)	quence of:
Sal	Comund of	othorax Ledays
Medical		
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna	
icia	in the past 12 months? 1 ☐ Ves 2 ☐ No 1 ☐ Ves 2 ☐ No	
Physician/	9 Unknown 9 Unknown	
y P	Part II. Other significant conditions contributing to death but not resu	sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ed	asthma	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Completed by		24a. Was an autopsy findings available prior to completion of cause of
E		autopsy prior to completion of cause of death? 1
Be C	25. Was case referred to medical	26. Place of Death (Check only one)
	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐	□ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury at Work? 28d. Describe how injury occurred
atio	2 Accident investigation	M 1 Yes 2 No
Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specification of the building of the bui	nome, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cer	Salaring, etc. (epocing	
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno and manner stated.	owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of continer	Olumber RES - 000 November 17, 2009
	30. Name and address of person who completed cause of death (Item	
to.	31. Date filed (Month, Day, Year) 32. Registrar's Signar	ature
ate rar	MON 0 0 2000 P	ature A. Jane
	MAN S 3 CANA YOUNG	

St Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are sociales State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:42 AM OR PCOS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GSH Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🖫 🗗 Months Days Hours Min. Director er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland Aty, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mor 10e. Street and Numb 10f. Zip Code 10g, Citizen of What Country? Funeral and Mental Hygiene. is marked other than "natural", or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever 11. Marital Status Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 2 permit. Page 1 and 2 should be filed v Department of Heatth and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maider Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or oth 1 Burial 2 Cremation 3 Removal from State nonation 5 ☐ Other (Specify) 4 🗆 70 21. Sign of Funeral Service Licensee 2/2/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician and Gastrointestinal Failure bleeding LIVEY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? hyperlension 24a. Was an certificate has page 2 autopsy yes 2 N 2 🗹 No 1 Yes Division of Vital 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 M Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 □ within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier erdany RESOOD 2009 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe BW. - Baltimore - MD 21239 Mahdi 5601 Loch Yazdany Raven 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

		For State	State of Maryl	and / Dep	artment of	Health and	•	_ ~ ~		37380
		Registrar 1. Decedent's Name (First, Middle, Last)		<i>Ue</i>	ertificate of	Deatri	2. Date of De	Reg. No.		3. Time of Death
Physicia /Medic		MARION ETHEL	BOSWELL				NOV NOV	14 Day	2009	1615 p M
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	th		y of Death	
		Prince Georges Hos			Chever		To Date of Dia		e Geor	
Funeral Director		5/9-64-1569	7. Age (In)	yrs. last birthday Yrs.	Months Days			v. Year)	9. Birthpla Count	ace (State or Foreign ry) DC
and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10	d. Inside City Limits
/laryl	ō	MD Prince Go	eorges	Foresty	rille					1 ∐Yes 2X No
the 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
3a ol	Funeral Director	2617 Phelps Ave.			2074	7		US	A	
death	ner		12. Was Decedent Ever in	n U.S. 13	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	- 14. Ra	ce - America	
after or ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐Yes 2X No		to Rican, etc.)		ack, White, et	tc.
ours ral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 165 2 2110	о ореспу.		Spec	^{ny:} B1a	ack
72 h "natu dieni	ete	15. Decedent's Educ (Specify only highest grade	cation e completed)) (Giv	edent's Usual Occu e kind of work done	during most of wo	rking	16b. Kind of I	Business/Indi	ustry
within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2yrs	I	DO NOT use retire ial Cler	•		Veri	zon	
filed Hygi other		17. Father's Name (First, Middle, Last)	2,720	- Spot	744 0202	T	me (First, Middle,			
ld be lental ked c	To Be	Charles Trowell				Lilliar	n Davis			
shou and N s mai	_	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mai	ling Address (Stree	t and Number or R	ural Route Numb	er, City or Tow	n, State, Zip	Code)
and 2 salth 27 i er tra		John W. Boswell-H	usband	2617	Phelps	Ave. For	restville	e, MD.	20747	
ges 1 t of H if iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	osition (Name of ematory or other pla		Date	20c. Location	- City or Tov	vn, State
Pag tment tant:		4 □ Donation 5 □ Other (Specify)	F	t. Linc	oln Cemet	ery 11-	21-2009	Brentw	rood, 1	1d.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experime must be notified at once.		21. Signature of Funeral Service License	C.Wood			§° ¥ਓਜ਼ੀera] land Rd.				
Physician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the decause on each line. Fatal Caro Due to (or as a con-	diac Arı		ring, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
wate be executed water and water and we burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	☐ Ectopic pregnar	ncy			ate of deliver	ry Day Year
uires that the de signed by the a ld be detached I	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying cause g	iven in Part I.				e cause of death?
Physician: The law require this certificate has been siral director, page 2 should I	Completed						24a. Was autop perfo 1 ∐ Yes	rmed?		sy findings available apletion of cause of
ician sertifi ector,	Be	25. Was case referred to medical examiner?	loonital:				ath (Check only o	ne)		
Phys	은	1 ☐ Yes 2 █No ☐	lospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 ☑ ER/Outpation	ant 3 1 DCA		Home 5 ☐ Resi 28d. Describe		_ , , ,)
ding Ph h. After th funeral	tion	1 ☑Natural 5 ☐ Pending	(Month, Day, Yea		Wo	ork? ⊡Yes 2⊡No	200. Describe	now injury occi	irred	
or Atten fter deat irector: n by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, s ecify)			28f. Location (. City or Tox		nber or Rural	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			sician: To the best of my ner: On the basis of exan							
the H hin 24 the F mplete	Medical	one)	and manner stated.				I I			
To co		29b. Signature and title of certifier	* *			nse number		29d. Date sign		
		30. Name and address of person who co	Herry M			0986		11-16	-200	39
10		VICTOR E. A	HERRY 9	00/3/6	DALARO	Rd CL	INTON	MD:	20735	
Sta Registr		31. Date filed (Month, Day, Year) NOV 2 3 2009	3. Registrar's Si	A. A.	aslas					

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

09-08430 Paul Edward Boss

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 37381

		1- For State Certificate C	of Death	Reg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Exam	ner	Edward Paul Boss		October 30, 200	09 1816 hrs
		4a. Facility Name (if not institution, give street and number) 6800 Highview Ave.	4b. City, Town, or Location of Deal Parkville		County of Death Saltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi Months Days Hours Mi rs.		DD/YYYY) 9. Birthplace (State or Foreign Country) MA
,		Usual Residence of Decedent			
w any		10a. State 10b. County 10c. City, Town or Loc MD Baltimore Baltin			10d. Inside City Limits 1 X Yes 2 No
yland f shc	į	10e. Street and Number	10f. Zip Code	140- 04	zen of What Country?
e Mar or 28s	ire			Tog. Citiz	× .
with th s 23a e noti	<u>=</u>	6800 Highview Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21206 /as Decedent of Hispanic Origin? (\$	Specify Yes or No-	U.S.A. 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important! If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director		Yes, specify Cuban, Mexican, Puert Yes 2 X No specify:	to Rican, etc.)	White, etc. Specify: White
ours at atural	ф (15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	ent's Usual Occupation (Give kind of	f work done 16b. K	Kind of Business/Industry
6 172 h an "n ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	, i	
within siene.	E	12 HVAC		ne (First, Middle, Maiden	-Evrama)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	Frederick Allen Boss	l l	Marion Rupe	·
212 ould b J Men s marl	P		ng Address (Street and Number or		
MD nd 2 sho alth and m 27 is			Highview Avenue		
ore, s l an of Hea If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or or or or or or or or or or or or or	osition (Name of cemetery, other place)	Date 20c. I	Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify: Ardent Cre	mation Services 11/	'20/2009 Han	nover, Maryland
Ball permit Depart Impor			Name and Address of Facility		emation Services
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	522 Connelley Dr the mode of dying, such as cardiac		
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds			Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):			
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	mine	cause. Enter Underlying Cause (Disease or injury that initiated			
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	//Medical	UNPENDED X AMENDED #1 as noted as	er ME g898 12/17	/00 mm	
760, ficate be g physic i the buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		230	d. Date of delivery
687 certific	ian/	Program at time of death	Fetal death 3 Ectopic pregi	nancy	Month Day Year
Box 68 e death certil the attending	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
that the ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
s, P.	d by			1 Yes 2	No 3 Probably 4 Unknown
ords w requ s been should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Recc The lar sate ha	Ē		·	performed? 1 ✓ Yes 2 N	death? lo 1 ✔ Yes 2 No
ian: ian: certific	Be	25. Was case referred to medical examiner?	26.Place of Death (Chec	k only one)	
of Vital Physician: er this certif	2	1 ✓ Yes 2 No			ence 6 Other: Scene
Division of Vital Records, P.O tal or Attending Physician: The law requires that tal the treated ath. The law requires that tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	ë	27. Manner of Death 1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND: 28b. Time of FOUND: FounD: FounD	f Injury 28c. Injury at Work?	28d. Describe how inju Subject shot by p	
Sio	cati	2 Accident Oct 30, 2009 1836 hrs		28f Location (Street a	and Number or Rural Route Number, City
Divis ospital or / hours after meral Dire	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	oot, idoloty, amoo bananig, ole.	or Town, State) 6800 Highview Ave.	
F 24 H		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, ar	nd due to the cause(s) an	nd manner as stated.
To the within To the comple	Medical	one) 2 • Medical Examiner: On the basis of examination and/or investige and manner stated.		at the time, date and pla	ace, and due to the cause(s)
-	Ž	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		Mex	O.C.M.E.	Oct	tober 31, 2009
	_	Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street Baltimore MD 2126	01	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Oueer, Dalimore, IVID 2120		
S Regis		NOV 9 9 2009	a de g		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Jest Herbert Barfoot 4:20 A M byember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death VA Maryland Heath Care 5
5. Social Security Number 6. Sex 17 Perru If Under 1 Year Point If Under 24 Hrs. 8. Date of Birth (Month, Day, June 28, Birthplace (State or Foreign Country) 1 🕅 M 2 🗆 F 1918 91 June Iowa 114-09-9810 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland| Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1653 Fendall Court 21114 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 21 No 3 ♥ Widowed 4 □ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) Proofreader Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert F. Barfoot Hazel Kietzke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith Mischou/ Daughter 9710 Sutherland Road Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/2009 Crownsville, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home |16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final railure disease or condition resulting in death) Due to (or as a consequence of): Obstructive Pulmorary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide

Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and attending physician for use as the buria

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f shov

Director

by Funeral

Completed

Be

with the Maryland

2121

Maryland

Baltimore,

Mental pe

or other traumatic

permit. Pages 1 and 2 shoul Department of Health and MM Importent: If item 27 is marl any inj. ry or other traumati once.

Physician

/Medical

Examiner Physician/Medical Certification: To

þ Completed Be

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number D5 2739

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Sirresh Shandelya, M.D., V. Mary hard Health Care System, Perry Point, MD 21902
31. Date filed (Month, Day, Year) 32 Registrar's Signature

within 24 hours a

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BATTS - KEBE, MAMMIE

Physician

/Medical

,				OSPITAL		BA	FLTIMOR	تا.		
	Funeral		5. Social Security Number	6. Sex 7. As	ge (In yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		212-46-1408 Usual Residence of Decedent	11.	61 "	5.		11 05	48	MD
	/land		10a. State 10b. Count	у	10c. City, Town o	r Location				10d. Inside City Limits
	Mary a-fsh	ţo	MD N	A	I	Baltimore	9			1 X Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	th wit		703 Charing	Cross Road		2	21229		U.	S.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
36	s afte	by F	1 ☐ Never Married 2 Ma 3 ☐ Widowed 4 ☐ Divorce	I ITYES GIVE	No	1 □Yes 2X No	Specify:		Specify:	Black
Ö Ö	hour	ed		ent's Education	16a. D	ecedent's Usual Occu	pation		16b. Kind of Busi	
215	in 72 in "in	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed)	· //	Give kind of work done fe. DO NOT use retire	during most of word)	orking		ore City
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-1 show umatic event, the fredeal Evaninar must be notified at	Completed	12th grade	5yrs+	J+)	Social W	lorker		Dept.	of Education
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle					me (First, Middle, I		
yla	thould be and Menta marked matic ev	ပ္	William B. B		· · · · · · · · · · · · · · · · · · ·		J	Willie		
Mar	~ ~ ~ 5		19a. Informant's Name/Relation	, ,						^{tate, Zip Code)} 21216 Baltimore, M
e,	1 and Health sm 27 ther tu	1 3	Mamie Batts- 20a. Method of Disposition	Butler-Dau					20c. Location - C	
٥	6 0 L L		1 X Burial 2 ☐ Cremation		cemetery,	isposition (Name of crematory or other pla emorial F	ce)		Woodla	
Baltimore,			4 □ Donation 5 □ Other (King M			/21/03	WOOGIA	wii /iia
Ba	permit. Departr Importa any Inje	g d	Frame.	1 Samon	int)	March F/	H West	e. Balti	more.	Md 21215
			23a. Part 1. Enter the disease, o	or complications that cause	d the death. Do not			-		Approximate Interval Between
	Physician	8 1	Immediate vuse (Final	st only one cause on each I	74 20 Vay	Y ARTER	V Niez	TNEE		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	s a consequence of):		7 9/30	HIL		2 DAXS
	Examiner		Cognentially list conditions	h						
-	pit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Card to (or se	a consiquence of					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):					
60,	icate be executed physician and the burial-transit			Due to (or as	s a consequence on.					
68760	certificate be executed adding physician and se as the burial-transit	Physician/Medical	4.0	d						
Box	eath certific attending p for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy				23d. Date	of delivery
m m	death e atte	icia	in the past 12 months? 1 ☐ Yes 2*☑No	4 ☐ Pregnant a	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		Mont	h Day Year
P. O.	that the de ned by the a detached t	hys	9 🗆 Unknown	9 ☐ Unknown						
Ś	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by F	Part II. Other significant condit	tions contributing to death t	but not resulting in th	ie underlying cause gi	ven in Part I.			ute to the cause of death?
ord	requir een s nould	ted	1177019		*			1 ∐ Ye	es 2∐No 3	Probably 4 Anknown
Records,	ician: The law requii certificate has been s rector, page 2 should	Completed	END S	TAGE RENAL	- DISEASI	3		24a. Was a autops	sv pri	ere autopsy findings available or to completion of cause of
<u>=</u>	: The icate ; pag		HEPAT	ITIS C				perform 1 □ Yes	med? de 2 /21No 1[ath? ∐Yes 2 □ No
Vital	lysician: lis certific director,	Be	25. Was case referred to medic examiner?	Hospital:		Ott	hor:	eath (Check only on		
ō	ding Phys h. After this of funeral din	.T	1 Yes 2 No 27. Manner of Death	1 Dinpati 28a. Date of Inj	ient 2 ER/Outpa	atient 3 DOA	4 L Nursing	Home 5 ☐ Reside	ence 6 Other	
0	ding h. After fune	tion	1.XINatural 5 ☐ Pendi		ay, Year) Inju	ry Wo	rk?]Yes 2 □ No	200. Describe no	ow injury occurred	
Division of	Atten r deat ctor: by the	Certification:	3 ☐ Sulcide 6 ☐ Could	Land ha	jury - At home, farm	street, factory, office		28f. Location (S	treet and Number	or Rural Route Number,
á	al or s afte	Sert	4 ☐ Homicide deter	building, e	тс. (Ѕреслу)			City or Town	n, State)	
	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director;		29a. Certifier (Check only 2 Medical	ing Physician: To the best	t of my knowledge, o	leath occurred at the t	ime, date and pla	ce, and due to the c	cause(s) and man	ner as stated.
0	the H nin 24 the F nplete	Medical	one)	and manner s						
	Vitt	2	29b. Signature and title of certifi	ar l		29c. Licen:		7		(Month, Day, Year)
			1/wh	y Hough	m !	10	2344	C M	DUEMBER	17, 2009
			30. Name and address of person	0 0 0			BALTIN	NORE M) 1	1229
	Sta	te	31. Date filed (Month, Day, Year		ATON AVI	INVE	UNCIT	WILL IVI	0 2	122
	Registr		MOV 9	3 2009 Mens	un A.	parket				
			THUY &	0		6-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item | per doc g898 12-29-09 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 Q

		•	State Registrar	Oldio of Marylan	Ce	rtificate of	Death		Reg. No.		3 31301
	Physicia	n/	1. Decedent's Name (First, Middle, Last					2. Date of Dea		year.	3. Time of Death
	Medic	al	Elizabeth V. Bohr		th V.			Novemb		6, 2005	
-	Examin	er	4a. Facility Name (if not institution, give: Stella Maris Host	·		Timon	or Location of Deat ium	n	1	County of Dea	
ı	Funeral Director		5. Social Security Number 6. Se 051-16-4732		ast birthday) Yrs.	If Under 1 Year Months Days			:h y, Ye-9 7)1 (9. Bi	rthplace (State or Foreign DuntryNew York
	how how	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	/arylar 8a-f s tified	Director	MD Baltimo	ore	Timoni	Lum					1 ☐ Yes 2X No
	n the N a or 2 be no		10e. Street and Number	1 // 0710		10f. Zip Code	1000		10g. Citi	zen of What C	ountry?
	th with ms 23 must	Funeral	2525 Pot Spring I	Road #S/13 12. Was Decedent Ever in U.S	140		1093	posify Vac or No		USA	days to Ban
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates.		If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert o Specify:	o Rican, etc.)		14. Race - Am Black, Whi Specify: W	
15-(72 hou n "nati ledica	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done O NOT use retired	during most of wo	rking	16b. Kir	nd of Business	Industry
212	within giene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	me. L	accounta	· .		fi	inancia	.1
Baltimore, Maryland 21215-0036	d be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) William John Vei	.t				me (First, Middle, Catherine			
, Man	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship (Ty Claudia M. Bohner	pe, Print) t/daughter	19b, Maili	ng Address (Street Dutton A	and Number or Ru venue Cat	iral Route Numbe CONSVIII	r, City or MI	Town, State, Z 2 1 2	in Code) 28
imore	Page 1 all Iment of H tant: If itel jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State		osition (Name of matory or other pla	ce)	Date	20c. Lo	cation - City o	r Town, State
Ball	permit Depart Impor any in	. 10	21. Signal of Funeral Survivisions	1 W		Baltimore	atomy Boa MD 21	201		ltimor	e Street
			shock or heart failure. List only or	lications that caused the death ne cause on each line.	n. Do not ent	er the mode of dyl	ng, such as cardiad	or respiratory an	rest,		Approximate Interval Between Onset and Death
1	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCU		CCIDENT					Onoce and Dodge.
4,50	Examiner		Constructed by the constitution	b. ———							
	D #	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
	ifficate be executed og physician and as the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	ence of):		-				
0	be ey/sician	Medical		d							
8760	tificate ng phy as the	Med	IF FEMALE:						$\overline{}$		
Box 6	Attending Physician: The law requires that the death certificate be executed er death. erdor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	☐ Ectopic pregnan☐ Other (specify)	cy		2	23d. Date of de Month	elivery Day Year
Division of Vital Records, P.O.	ires that the signed by Id be detact	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the	underlying cause g	iven in Part I.				o the cause of death? Probably 4X Unknown
ecord	ne law requ e has beer age 2 shou	Completed						24a. Was autor perfo	osy ormed?	prior to death?	utopsy findings available completion of cause of
a	ilan: T	Be C	25. Was case referred to medical examiner?				Place of Death (Che	1 🗌 Yes ck only one)	ZALI NO	1 1 16	S Z L NO
Ĭ.	Physic this ce al dire	은	1 ☐ Yes 2 X No	1 Inpatient 2	ER/Outpatie		4 L Nursing I				cify) HOSPICE
n 0	ding f th. After funer	cate	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	injury	wor		28d. Describe h	ow injury	occurred	
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, sti			28f. Location (S City or Tow		Number or Ro	ural Route Number,
_	ne Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2 Medical Examin	ician: To the best of my knowled ner: On the basis of examination to e Practioner: To the best of my	and/or inves	stigation, in my opin	ion, death occurred	at the time, date a	and place,	and due to the	cause(s) and manner stated
	Vithi Vot	_	29b. Signature and title of certifier	1 1		29c. Licens		7	29d. Date	e signed (Mon	th, Day, Year)
	•		MA	char	00.) =		SOSS	1		116/5	109
			30. Name and addless of person who o	ompleted cause of death (Item 12 2300 DULAN)			TTMONTIN	1, MD 210	093		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat		who					
	Registra	वा	MOI NO TO	1							

5:35 а.ш.

NOVEMBER 16, 2009

ELIZABETH BOHNERT

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vear ROXANNE G BURGE NOVEMBER 5,2009 1:24P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔯 212-62-3765 Mar 15, Director 1953 56 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Frederick Frederick 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21702 **USA** 1900 Rosemont Avenue 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Be Completed unk CHES 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 W. Seventh Street Frederick, MD Frederick Memorial Hospital Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. So a use of Euneral Service Licensee Wards, Director State Anatomy Facilibard 655 W. Baltimore Street 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate thuse (Final disease or condition resulting in death)

a. CIZAM NEGATIVE SEPSIS 21201 Baltimore, MD Approximate Interval Between Onset and Death **Physician** カカソら /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner d and leading to trime da cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coast of case processories of certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown הייבי נחוא certificate has been s funeral director, page 2 should I Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 10 No 1 Yes or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 € 1 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 20061410 2009 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD GAFFAR TOLL HOUSE - HE FREDERICK 801 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

1515 M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

MA.

Black, White, etc.

P.O. Box 195

MS 42865 NOV 20 2009 BUX LAWE COLUMBIA, MD

Approximate

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CES CALLENDE NOV /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 1 M 2 □ F 86 034-14-5696 11/24/1922 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show MD. Howard Dayton ms 23a or 28a-f sh must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4521 Ten Oaks Rd. 21036 USA Funeral ıral", or Items 2 I Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Engineering 4Yrs. Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot 1 and 2 should be Charles Clark Emma Jean Miriam ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Shamim Iftikhar(Friend) 13448 Allnott Lane Highland ,Md. 20777. permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/2009 Howard County, MD. Crestlawn Mausoleum 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. Sykesville, M. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition RUMIKES ABSONWAL ACKTIC ANEUKEM Physician /Medical Examiner Examiner Division or Vital Records, P.O. Box 68760, Physician/Medical

The law requires that the death certificate be executed signed t

page 2 s within 24 hours after death

To the Funeral Director: filled in by

the Hospital or Attending

Be Completed by

Medical Certification: To

IF FEMALE: 23b. Was decedent pr in the past 12 m 1 ☐ Yes 2 ☐ N 9 ☐ Unknown
Part II. Other significa
25. Was case referred examiner?
1 Ves 2 No

shock, or heart failure. List on				Interval Between
mmediate Cause (Final disease or condition esulting in death)	Due to (or as a consequence of):	SOUWHL ACK	TIC ANA	OKSM HOUKS
equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury nat initiated events esulting in death) Last	c	cuelosis		
	d			
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
art II. Other significant conditions	s contributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Anknow
			24a. Was an autopsy performed 1 Yes 2 ■	
Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing F	Home 5 Residence	e 6 □Other (Specify)
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred
3 ☐ Suicide 6 ☐ Could not determine		eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
Pa. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death aminer: On the basis of examination and/or in and manner stated.	n occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
9b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

State Registrar

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	State of Maryland / Department of Health and Mental Hygiene	

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year PATRICIA CROSLAND Α. NOV 16 2009 1740 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🛛 F Min Director 62 237-76-0758 Nov. 6, 1947 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exeminar in ust be notliked at Director 1 ☐ Yes 2X No MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1101 Castlewood Dr. 20774 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 5 Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Inc. Once. 12th Customer Service Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Fleming Crosland Esther Swinney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Murray - Daughter 1101 Castlewood Dr. Upper Marlboro, MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 11-23-2009 Landover, Md. 21. Signature of Funeral Service Licensee Marshall s funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISCUSE LAND disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Kenal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 25mil HI worn have 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No Physician: The certificate 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO1852 No. Punhar 17 2029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbory Rel Hyatts: 1/e MD 20781 MI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2009 Ceci1 Vernon Clagg, Jr. November 3:20am Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 112 Charlgate **Baltimore** Owings Mills 9. Birthplace (State or Foreign Country) 5. Social Security Number Funeral . Age (In vrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 X M 2 □ F Months Days Hours Min Director 236-46-2783 76 WV Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Baltimore 1 🗆 Yes 2 💢 No Owing Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Charlgate Road 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. þ 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Years Professional Truck Driver <u> Mountain Side Trucking</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Vernon Clagg, Sr. Nellie Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Virginia Clagg (Wife) 112 Charlgate Road Owings Mills, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 11-25-2009 Sykesville, MD Signatu of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling Eline Funeral Home Reisterstown, MD 21236 Post 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ulluc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director; page performed? Yes 2 No 2 1 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3/322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 MADEN CHOICE (N, CATONSVILLE, M) 2/226 MD GARG

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #27 Per ME (8897 11723709 TT State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2009 1:36 PM Fan Tung Chu November 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctor's Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Days Hours Year) Months Min. 1 □ M 2 💢 F 96 215-88-5031 China April 12, 1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2\\No Pricne Georges Maryland Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6606 Alexis Drive 20720 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Specify: 3X Widowed 4 □ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pu Kung Tung Yuan Hsu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6606 Alexis Drive Bowie, MD 20720 Gen Sen Chu/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Skyline Memorial
Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/23/2009 Monee, IL 21. Signature of uneral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acuti Myocandial disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due (or as a consequence of): Alz hermer resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 21 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 11X Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1' Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury UNK 28d. Describe how injury occurred 1 A Natural 2 A Accident 5 Pending investigation November 12 1 ☐ Yes 2 ☐ No 2009 28f. Location (Street and Number or Rural Route Number City or Town, State) Aut was A KAVANAY 6 ☐ Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide Assisted Living 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 and medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Director

Funeral

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Completed

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Important: If item 27 is marked other any injury or other traumatic event, If once.

1 and 2 should be filed withi Health and Mental Hygiene.

Pages 1 ₽

Department

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician for use as the burial þ certificate has page 2 After this funeral spital or Attendi lours after death. neral Director: A filled in by the fu death.

Completed by

Be

Certification: To

Medical

29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

within 24 hours a

GALLANT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

ArorA

29c. License number

MDD20108

29d. Datę signed (Month, Day, Year)

FOX LANE suite 222 Bowie, MD 20715

		For State Registrar	State of Marylan		artment of rtificate of		nd Mental H	ygiene Reg. N	2000	37390
		1. Decedent's Name (First, Middle, Last)					2. Date of D	eath Day	Vear	3. Time of Death
Physic /Med		John Adam Ciesiels	i				Novemb	er 2	1, 2009	11:15a ^M
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death ms 2; r mus	Funeral		2. Was Decedent Ever in U	.S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	10- A	America 14. Race - Amer	
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ylal Menta Menta arked	2	Stanley Adam Ciesie	elski	.,			ille Edith			
2 shown and is m		19a. Informant's Name/Relationship (Typ		İ			or Rural Route Num			21074
T and T and Health		Mary Anne Eisenache	20b. I	Place of Dispo	sition (Name of		on Road, H		cation - City or	+
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portinitions, interpretation 212.13-0030 p-rmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signators of Funeral Service License			ematory 2. Name and Add	ess of Facility	Eckhardt	Funer	cal Char	e, Maryland bel, P.A.
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/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):						1
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2										
Hosp 24 hou Fune etely f	edical		ician: To the best of my kno ier: On the basis of examina and manner stated.							
Fo the Vithin Fo the	Me	29b. Signature and title of certifier			29c. Licer	se number		29d. Dat	te signed (Month	, Day, Year)
		[1 KU]			000	5190	24	Nov.	enhei	23,2009
		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	14		1	. ^ >	1167
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37391 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vonda Edison Cox 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Franklin Square Hospital Rosedale Battimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Sex 7. Age (In yrs. last birthday) 1 □ M 2 💢 F Months Days Hours Yrs 229-09-3925 91 <u> 12/14/1917</u> Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore **Essex** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Savannah Road 21221 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2XX No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burton Isaac Stella Mullins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Melvin Cox (Son) Baltimore, Maryland 21205 1006 Quantril Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Donation 5 ☐ Other (Specify) Holly Hill Mem Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplications disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 2 **N**O 1 □ Yes

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Medical Expriner must be notified at once.

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

/Medical

10a. State

Director

Funeral

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Completed

Be 2

Examine

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Certification: To

law requires that the death certificate be executed After this funeral (To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral

State Registrar

Medica

25. Was case referred to medical examiner?

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

Hospital: 1 Yes 2 No 27. Marvier of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

10069529

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Drive Bathmore, MD 21237

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Navember 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

9000 Franklin Square 32. Registrar's Signature

31. Date filed (Month, Day,

A. park

09-08821 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Roland Davis 2009 37392 State of Maryland / Department of Health and Mental Hygiene

		Registrar	Ochlino	ate of Death	Reg. I	No.	
Physicia	in/	1. Decedent's Name (First, Middle,L	.ast)		2. Date of Death		. Time of Death
Adical Exami		David Dala	Davic		Month Da	y Year	1555 hrs
		4a. Facility Name (if not institution,	na vavis		November 13		
				4b. City, Town, or Location of D	eath	4c. County of Death	
		721 Edmondson Avenue)	Catonsville		Baltimore Coun	ty
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24	4Hrs. 8. Date of Birth(N	IM/DD/YYYYY 9. Birthr	place (State or
Director		220 12 7201	5		Min	Foreign	00
		a30-6a-7306 1	XM 2□F 65	Yrs.	05/171	1946 Coun	try)
		Usual Residence of Decedent					
Any		10a. State 10b. County	10c. City, Town	or Location		1	Od. Inside City Limits
_ \$ 41		111	172-1	1:00.00			Yes 2 No
faryland 28a-f show	ō	IAID	<u> </u>	timore			Tes 2 INC
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Director	10e. Street and Number	Α Α	10f. Zip Code	10g. (Citizen of What Country	/?
ing h	ā	721 Edmond	son thenue	21228		ILSA	
# 2 3		11. Marital Status	V			0.0	
th w	uneral	1 Never Married 2 Marri	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		 Race - America White, etc. 	n Indian, Black,
dea or it	ᇍ	Never Married 2 Iviairi	1 Yes 2 No	respective and it moximum, re	ono modif, otc.)	vviille, etc.	
ffer ffer ffer ffer ffer ffer ffer ffer		3 Widowed 4 Divorc	ed If Yes, Give Year	1 Yes 2 No specify:		Specify: 5	
hours afte "natural"; Examiner	Ď	15. Decedent's Education (Specify	only highest grade completed) 16a	Decedent's Usual Occupation (Give kind	of work done	. Kind of Business/Ind	
Franch hou	eted	Elementary/Secondary (0-12)		during most of working life. DO NOT use		o. Kind of business/ind	usiry
92 43	e	Lienteniary/Secondary (0-12)	College (1-4 or 5+)	1.		1 11 11	1
Ar P. B. Arbii	Ē		2 H	ntique buyer	r = 10	oller tik	des
21215-0036 uld be filed within 72 Mental Hygiene. marked other than	Comple	17. Father's Name (First, Middle, La	st)	18.Moviller's N	ame (First, Middle, Maid	en Surname)	, , , , , , , , , , , , , , , , , , ,
a a E E	Be	Hurley Va	1150	Lilia	a Davis	anat	
2121 ould be fi Mental I marked		19a Informant's Name Relationship	ViS	I FINC		port	
	P	19a Morniarit s Mainer Relationship	(Type, Print)	b. Mailing Address (Street and Number	or Rural Route Number,	Cit. or Town, State, Z	_
E 0 - 0 -	-1	Jay 1. Davis	Daughter) 2	109 E. Federal O	treet ba	eto, mo	21202
_ 4 7 7 7	- [20a. Method of Disposition		of Disposition (Name of cemetery,	Date 20	c. Location - City or To	wn. State
F E S S		1 Burial 2 K Cremation 3	Removal from State cremat	ory or other place)	1 1 - 1 -	D 11	1
Pag Pag Pag		4 Donation 5 Other Speci	ty: Gree	n Mount 11	1/23/09	Kultimo	ro.MW
Baltimore, permit. Pages I a Department of He Important: If ite	- 1	21 Signature of Funeral Service Lice			-00-0 F	000.	Nices
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Dharisis	-	23a Part I Enortho discoss or con	and in the death of the death o	1515 Balto. No	at 1 Pile	(21719	
Physician	ı	failure. List only one cause on	each line.	t enter the mode of dying, such as cardia	ac or respiratory arrest, s		Approximate Interval Between Onset and
/Medical	-	Immediate Cause (Final disease	a. Atherosclerotic Cardiovascu	lar Disease			Death
Examiner	- 1	or condition resulting in death)	Due to (or as a consequence of):			4.	
	- 1						
	اڃ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	ĕ۱						
	-	cause Enter Underlying Cause	=5				
	٦	(Disease or injury that initiated	c			- 10	
isi ed	Exami	cause Enter Underlying Cause	=5				
Secuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	c				
e executed sian and ial - transit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			,	
ੂ ਲੋਵ		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): d. AMENDED			,	
ੂ ਲੋਵ		(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy			3d. Date of delivery	
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sion of Vital Records, P.O. Box 68760, ttending Physician: The law requires that the death certificate be exteath. ctor: After this certificate has been signed by the attending physician with funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 33b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigal	Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of solution of contributing to death but not resulting Contributing to death but not resulting 1 Inpatient 2 ER/Outcome 28a. Date of Injury (Month, Day, Year) 28b. Place of Injury At home for	Other (Specify) g in the underlying cause given in Part I. 26.Place of Death (Che stpatient 3 DOA Other Nurime of Injury 28c. Injury at Work?	23e. Did tobacc 1 Yes 2 24a. Was an autopsy performed 1 Yes 2 ✓	o use contribute to the No 3 Probabl 24b. Were autop prior to com death? No 1 Yes dence 6 Other: Sc	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No
sion of Vital Records, P.O. Box 68760, uttending Physician: The law requires that the death certificate be exteath. ctor: After this certificate has been signed by the attending physician with funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investiga 3 Suicide 6 Could no determine the past of the p	Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of for death 9 Unknown contributing to death but not resulting to d	Other (Specify) 26.Place of Death (Che tpatient 3 DOA Other Num 28c. Injury at Work? 1 Yes 2 No	23e. Did tobacc 1 Yes 2 24a. Was an autopsy performed 1 Yes 2 ✓	o use contribute to the No 3 Probable 24b. Were autop prior to com death? No 1 Yes dence 6 Other: So	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No
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Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be expours after death. neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial	a Certification: To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investiga 3 Suicide 6 Could no determined 29a. Certifier 1 Certifying Physicians (Disease)	Due to (or as a consequence of): d. AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death go Unknown contributing to death but not resulting to deat	Other (Specify) 26.Place of Death (Che tpatient 3 DOA Other Num 28c. Injury at Work? 1 Yes 2 No	23e. Did tobacc 1 Yes 2 24a. Was an autopsy performed' 1 Yes 2 ✓ ck only one) rsing Home 5 Residence R	o use contribute to the No 3 Probabl 24b. Were autop prior to com death? No 1 Yes dence 6 Other: So nigury occurred	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No cene

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Registrar

29d. Date signed (Month, Day, Year)

November 19, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9512 16 as by 19a / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 615 Gilda Donaldson ben be Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 9. Birthplace (State or Foreign 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 1 M 2 X F S(Month, D2)7 Year) 1924 Country) 220-22-1033 85 Director Marv1and Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 N. Charles Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Employee Postal Service US Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) **Betty Hills/friend**Union Memorial Hospital 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 201 E. University Pkwy Baltimore, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state 21. Signatur of Euneral Service Licensee Rorald S. Made Director State and Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown Hypertensian 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 🗆 Inpatient 2 🗀 ER/Outpatient 3 🕱 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10W man

State Registrar 31. Date filed (Month, Day, Year) NOV 2 3 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10140 M 1001 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltinore IMMO 5. Social Security Number Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 😿 F Months Hours Director 216-72-5007 02/06/1962 Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f sh MD 1 Yes 2 No Funeral Director Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, Ite Medical Examinate rust be 1 3525 O'Donnell Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Griffitts ပ Hattie Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Griffitts/Brother 8303 Kavanagh Road, Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematicn Services | 11/23/2009 Hanover, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ardent Cremation Services 7522 Connelley Drive, Ste.N. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WWW OXY **Physician** 6:19teral Due to (or as a cons - uence of): /Medical Examiner cell Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami interor vena CAVA Due to (or as a consequence of): Physician/Medical OFGAN 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Jyes 2□No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been si page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner^e Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 24 hours after death. e Funeral Director: A letely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

the Maryland

Baltimore, Maryland 21215-0036

the within 2

> State Registrar

Medical

29a, Certifie

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

23

Greene St.

32 Registrar's Signature

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore MD 71201

29d. Date signed (Month, Day, Year)

2009

Division of Vital Records, P.O. Box 68760,

Physician

/Medical 4a. Facility Name (If not institution, give street and number) Examiner The Woods Of Sun Valley 5. Social Security Number **Funeral** 212-52-7621 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical France. 10a. State Funeral Director Md. 10e. Street and Number 624 Watersville Rd 11. Marital Status 1 Never Married 2 Married 9 3 Widowed 4 □ Divorced Completed Elementary/Secondary (0-12) 12yrs 17. Father's Name (First, Middle, Last) Be Remus G. Green 2 19a. Informant's Name/Relationship (Type. Print) Mary Streaker(Daughter) 20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniceas or injury that initiated events resulting in death) Last Examine Hospital or Atter ding Physician: The law requires that the death certificate be executed burial-tran physician Physician/Medical attending p IF FEMALE 23b. Was decedent pregnant in the past 12 months? signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 this certificate has been s al director, page 2 should Completed 25. Was case referred to medical examiner? Be Other: 4th Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending after death.
Lirector Afd n by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely f (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H53939 11/23/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Inancel, Do; 218 washington Heights Med Ctr; Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. P State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TTEM#8perFH, 6898, 12/3/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Kathleen Theresa Finnegan 0305 AM 22 2009 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT AGINES HOSPITAL BALTIMORE 8. Date of Birtt 9/25/1933 9. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F Days 213-30-1243 Director 76 Sept. 14, 1933 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show at "natural", or items 23a or 28a-f sh cical Evaminer must be notified Director 1 ☐ Yes 2 ☑ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5525 South Meadwick Garth 21228 by Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Sales Analyst SC Johnson Wax Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Joseph Finnegan ည Mary Elizabeth Tierney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Packard Niece 39 Cedarhill Road; Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 11/25/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY PAILURE MINUTES /Medical Due to (or as a consequence of): **Examiner** AORTIC ANEURYSM 3-4 4 EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) AORTIC DISSECTION 3-4 YEAR Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical YEAR ARTERY DISEASE CORONARY nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Day Year 5 Other (specify) the detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ BIOPROSTHETIC AORTIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown director, page 2 should Completed HYPERTENSIOD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death e Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the

2

KATHLEEN

FINNEGAN,

State Registrar 31. Date filed (Month, Day, Year)

admixa

- , M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

RADHIKA KALISETTI, 900 CATON AVENUE, 32. Registrar's Signature

29c. License number

P22002

BALTIMORE,

29d. Date signed (Month, Day, Year)

MO - 21229

NOVEMBER, 2210, 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TTEM#2perDVR#7, 8, perFH, G898, 12/2/09, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MBER Pay 3. Time of Death Physician/ 2:50P M Mary Ellen Grue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Center Saint Joseph Medical Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1919 9. Birthplace (State or Foreign **Funeral** Days Min 1 🗆 M 2 🔀 F Months Hours $\mathsf{NoV}^{(Month,} T^{av}$ **-**Mary*lta*nd Year 918 91_90Yrs Director 215-07-7230 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Timonium Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21093 USA Unit 101 3 Glenamoy Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Murphy Danaker John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 20 Aliceview Court Gathwright/Daughter Linda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grid. 11/24/09|Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licens Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ASCENDING CHOLANGITIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHOLEDOCHOLITHIASIS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed CHOLECYSTITIS attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **ESOPHAGEAL** STRICTURE 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2**X** No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) long November 19,2009 D17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON. MARYLAND 21204 ABDALL HB. M. D. 31. Date filed (Month, Day, Year) /32. Registrar's Signature racks 2 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37398 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Mabel Alice Hannon 1158 AM November 18 2009 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Bathware 4c. County of Death Hospita If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year, 09-04-1931 Birthplace (State or Foreign Country) 1 □ M 2**X**□ F Months Days Hours Min. 218-28-9112 78 Yrs. Virgińia Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 Yes 2XXNo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane 9G16 21228 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ∐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Administrator Army Corp of Engineers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Urbin Lynch Marie Burdette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Stansbury Rd., Pilesville, MD 21132 Steven Hannon/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11-24-2009 Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 21. Signature of Funeral Service Lidensee W01020 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Rreunovia Onset and Death Immediate Cause (Final PIPATION Hows disease or condition resulting in death) Due to / as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2∑No autonsv perform 2 No 1 □ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner Examir certificate be execute and Physician/Medical

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show digni Evar i not to notified at

the Medical

Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23:

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evone.

Baltimore, Maryland 21215-0036

Director

by Funeral

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MD

with the Maryland

/Medical

burial-tran attending physician the use ō cate has been signed by the page 2 should be detached certificate

Box 68760

P.0.

Division of Vital Records,

Hannon, Wabe

this

e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera within 24 hours aft To the Funeral Di completely filled in

12

To the I within 2

þ Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Thipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

29b. Signature and title of certified ins 29c. License number

18,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merchant, MP Shaut

Caton Avenue

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Shirley Elaine Horan 2000 Vovembe 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🗖 F Days Hours Country) Maryland 212-30-1368 June Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 MYes 2 □ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 West Belvedere Ave. 21212 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dog Pets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Burton Horan Emily Marie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Sacred Heart Lane, Reisterstown, MD. 21136 Don Horan - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Nov. 21,2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee . Huto Wellett 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial trute unknown Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion of death? performed 1 □ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examiner Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

show

?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it a Madical Exp. in at must be notified at

is marked other than

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In a M

within 72 hours after death

Baltimore, Maryland 21215-0036

as the burial-tra ned by the attending physician detached for use as the buria Physician/Medical use Completed by pe page 2 should has certificate filled in by the funeral director. Be ical Certification: To after death

ものRAM らわi RIモU Division of Vital Records, P.O Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 🗗 No 28a. Date of Injury (Month, Day, Year) 27. Manner PDeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

31. Date filed (Month, Day, Year) State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of contifier

NOV 2

B19619430

💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanjay Pattum, MD, 900 South Catm Ate

ed cause of death (Item 23a) (Type, Print)

900 South Caton Avenue, Bathmori Maryland, 21229 32. Registrar's Signatur

within 24 hours a

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) November 19, 2009 **Physician** 8:04 A M William Ronald Howe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Laurel Regional Hospital 8. Date of Birth Month Day, 1940 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 XM 2 F Washington, DC 577-54-4598 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County variment of Health and Mental Hygiene.

oorlant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov
Injury or other traumatic event, the Medical Examinating must be notified at 1 ☐ Yes 2 X No Laure1 Director Prince Georges Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20708 11814 Randy Lane Funeral filed within 72 hours after death v I Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 □ No fYes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Š White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) United Parcel Service Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be lealth and Mental UNK UNK Naomi. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11814 Randy Lane, Laurel, MD 20708 Linda Ann Howe-Wife permit. Pages 1 a
Department of Hes
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. 22,2009 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fleck Funeral Home, INC. Signature of Funeral/Service Licensee Mo1234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e pulline. Approximate Interval Between Onset and Death Immediate Cause (Final Ol **Physician** disease or condition resulting in death) /Medical Due to (or as a persequence of): Examiner Si Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 X No 1 ☐ Yes 2 No 24 hours after death.

Funeral Director: After this certific stely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Hospital

State Registrar

the within 7 Ca

29a. Certifier (Check only

29b. Signature and title of certifier

and manner stated.

29c. License number M69 247

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Tourky MD, 7300 Van Dusen Rd., Laurel, MD 20707

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Artese S. Johnson 9:35 a^M 2009 01 Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Shady Grove
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 F 3-22-1987 578-13-6920 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location show 10a. State 10b. County ir Items 23a or 28a-f shov 1 XYes 2 No Director Germantown Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2239 Savannah Terr. SE 12930 Boggy Trailway 20020 death with 20076 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Never Married 2 ☐ Married 2 **X** No altimore, Maryland 21215-0036 ö 1 □Yes 2 No Specify. Specify: Black 3 the Medical Exa-3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Block Buster Manager 11th Uth and Mental Hygie

27 is marked other

r traumatic event, II other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Tracey Darnise Johnson Arthur S. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12930 Boggy Trailway
Germantown, MD 20876 19a. Informant's Name/Relationship (Type. Print) Health a Tracey Johnson permit. Pages 1 and : Department of Health Important: if Item 27 eny Injury or other tr. once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-11-09 Washington, D.C. Mount Olivet 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility D.L. McLaughlin Funeral Home Washington, D.C. 2002 2019 MLK Jr.Ave.S.E. Approximate Interval Between 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Minutes Immediate Cause (Final Acute Dysrhythmia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Minutes Respiratory Distress Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ██No Day 5 ☐ Other (specify) P.O. been signed by the should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à Systemic Lupus Erythematosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Neutropenia Anemia, Severe Metabolic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t rector, page 2 s autopsy performed? Yes 2 10 No Acidosis, Uremia. dvt 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐Xes 2☐No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Attending F 5 Pending investigation 1 Natural M 1 ☐Yes 2 ☐No spital or Attendinous after death.

neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 11-01-2009 D53887 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Shady Grove Adventist 9901 Medical Center Dr. Rockville, MD 20850 Orlee Panitch 31. Date filed (Month, Day, Year) NOV 2 3 200 32. Registrar's Signature State ark Registrar

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Mrs. Laura DePinto - Siste 79 BayView Drive West Sag Harbor N. 11963 Z06 Memory of Deposition West Arundel Crem. 11-24-09 Odenton, Maryland 11-24-09 Odenton, Maryland 12 Name and Address of Pacility Joseph N. Zannino Jr. F. H. 263 S. Conkling St. Balto. Md. 21224 Physician Common St. Deposition St. Balto. Md. 21224 Sale Part Interfered Bases, or complications that caused the death. Do not enter the mode of eight guester or condition resulting in death. Sale Part Interfered Bases, or complications that caused the death. Do not enter the mode of eight guester or condition resulting in death. Sale Part Interfered Bases, or complications that caused the death. Do not enter the mode of eight guester or condition resulting in death. Sale Part Interfered Bases, or complications that caused the death. Do not enter the mode of eight guester or condition resulting in death. Sale Part Interfered Bases, or complications that caused the death. Do not enter the mode of eight guester for conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or conditions and the sale of eight guester or guester or guester or conditions and the sale of eight guester or guester or conditions. The sale of eight guester or g							te, Zip Code)
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Physician (Modical Gaminer 232 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiar familiars. List only one cause on each line. 232 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiars. List only one cause on each line. 232 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiars. List only one cause on each line. 232 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiars. List only one cause on each line. 238 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiars. List only one cause or neach line. 239 Part. If there by glasses, or complications that caused the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart familiars. List only one cause or neach line. 240 Part arrest line in the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart. 250 Part arrest line in the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart. 251 Part arrest line in the death. Do not enter the mode of sying, such as cardiac or respiratory arrest, shock, or heart. 252 Part arrest line in the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Shock, or heart. 253 Part arrest line in the death. Do not enter the mode of sying, such as cardiac or respiratory arrest. Shock, or heart. 254 Part arrest line in the death. Do not enter the part of sying such as cardiac or respiratory arrest. Shock, or heart. 255 Part arrest line in the death. Do no	Itin Puritine Puritin						
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3 X Suicide determined (Specify) found at residence 147 N. Ellwood Ave Baltimore 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. November 19, 2009 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Name find address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 32. Registrar's Signature	the de	Ph		underlying cause given in Part I	23e. Did tol	pacco use contribute t	o the cause of death?
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Part of the part o	bspita hours neral	5	4 Homicide (Grossy) I Surface 200 Contifers		147 N. 1	Ellwood Av	e Baltimore
29b. Signature and title of certifier 29c. License number O.C.M.E. November 19, 2009 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 32 Registrar's Signature	n 24 l		(Check only Certifying Physician: To the best of my knowledge, death occu	rred at the time, date and place, and	due to the cause	e(s) and manner as sta	ated.
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30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 32 Registrar's Signature		Σ	29b. Signature and title of certifier				
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State 31. Date filed (Month, Day Year) 32 Registrar's Signature							
				Penn Street, Baltimore, MD	21201		
Registrar NYV & J 2003 (Lyoung S. Lyonger)			MIT II V V V V M M 10 1 V V V V M 10 10 10 10 10 10 10 10 10 10 10 10 10	No D			

09-08998 Dennis Kane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia		Registrar 1. Decedent's Name (First, Middle	,Last)						2. Date of Dea Month Novembe	ith	Year	3. Time of Death	1
edica	I Exami	ner	Dennis 4a. Facility Name (if not institution	ative stands and any	Mbos\	ane I4	b. City, Tow	or Location	on of Death	Novembe		09 County of Death	1420 1110	$\frac{1}{2}$
			10110 Harford Road	, give street and not	(IDel)	"	Parkville				Ba	Itimore Cour	•	
F	uneral		Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1		Inder 24Hrs.	8. Date of Bi	rth (MM/DI	O/YYYY) 9. Birth Cou	nplace (State or Foreign ntry)	1
C	irector		214-38-8340	1 XM 2 F	67	Yrs.	Months	Days Ho	ours Min.	8-2-	1942	Mar	yland	-
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	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Ma	arried Armed Fo		S. 13. Was	s Decedent on es, specify C	of Hispanic uban, M exi	ican, Puerto	pecify Yes or N Rican, etc.)		White, etc. White	oan maran, Dasky	
		. –		1 Yes	2 X No		Yes 2				S	Specify:		_
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36	in 72 h han "c Jiest E	ompleted	Elementary/Secondary (0-12)	College (1	1-4 or 5+)	Sa]	lesma	n				les		
00-	ed within 7 tygiene. other than	Som	17. Father's Name (First, Middle,	Last)						e (First, Middle	, Maiden S	Surname)		٦
21215-0036	l be file ental H arked vent, I	Be	unk			405 Mailine	Address		ink	Pural Route N	ımber City	y or Town, State	. Zip Code)	\dashv
D 2	and 2 should be filed within 72 hours after death with the Maryland teleth and Mental Hygiestelle than "matural", or items 23a or 28a-f sho traumatic event, the Medic at Examiner must be notified at once traumatic event, the Medic at Examiner must be notified at once	2	19a. Informant's Name/Relations John E. Hock		nd							Road 2		
Baltimore, MD	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiera. In prortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition		20b.	Place of Dispos	ition (Name	of cemeter	y,	Date		ocation - City or		\int
mor	Pages ent of int: If		1 X Burial 2 Cremation 4 Donation 5 Other Sp		rom State Sa	crematory or ott cred I							e, Marylan	ᆚ
aaltii	epartm nports njury o		21. Signature of Funeral Service	Licensee		22. N	lame and Ad	Idress of Fa	acility JO	seph	N, Z	annino	Jr. F.H. Md. 21224	.
	ysician		23a. Part Enter the disease, or	complications that	caused the death	. Do not enter t	he mode of	dying, such	as cardiac	or respiratory a	rrest, shoo	ck, or heart	Approximate Interval Between Onset and	" [
1	Medical	1	failure, List only one cause Immediate Cause (Final disease	on each line.									Death	
	:aminer		or condition resulting in death)		a consequence o									
		ē	Sequentially list conditions, if any, leading to immediate		a consequence	of):								٦
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X	vecuted n and - transit	Ë	events resulting in death) Last	d										_
Γ.	e be exec ysician a burial - 1	edical	UNPENDED	AMENDED							100	. Date of deliver		
68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Internet Directors: After this certificate has been signed by the attending physician and helv filled in whe finered director, nace 2 should be detached for use as the burial - transi-	an/Me	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of pre-		etal death	3E	ctopic pregr	nancy	230	d. Date of deliver Month	Day Year	
Box 6	eath certificate attending phy for use as the b	Sicis.		den aven	nant at time of d	eath 5 0	ther (Specia	ý)						
<u>я</u>	the dea	Phys	Part II. Other significant condi	9011K1	to death but not	resulting in the	underlying o	ause given	in Part I.	1			the cause of death?	Т
P.0	ires that signed l	<u> </u>	<u> </u>	-						1 🔲	Yes 2		obably 4 V Unknown	_
Records,	requir been s	Completed	_								topsy	24b. Were a prior to death?	utopsy findings available completion of cause of	le
ွှင် (ရင်	The law									1 ✓ Y€	erformed? es 2 N	posterior and the same of the		
tal F	cian: The certificate ector, page	Re		al Hospital:		ER/Outpatier		Oth	Death (Chec	k only one)	Reside	ence 6 🗸 Oth	er: Scene	_
of Vital	Physic Printer Praction	٦	1 Yes 2 No		Inpatient 2 te of Injury hth, Day, Year)	28b. Time of		Bc. Injury at				ury occurred		_
o uo	ending Plath. ath. or: After	1	1 Natural 5 Per	nding	th, Day,Year)			1 Yes	2 No					
Division	pital or Att ours after de teral Direct filled in by	ortification.	2 Accident Investigation 3 Suicide 6 Cou	uld not be	ace of Injury - At	home, farm, stre	eet, factory,	office build	ing, etc.		n (Street a n, State)	and Number or F	Rural Route Number, Cit	ły
	bspital hours ineral	ح د	29a Certifier	ermined (Specification (Specification)) Physiclan: To the b		adae death occi	urred at the	time date a	and place, a	nd due to the o	ause(s) ar	nd manner as st	ated.	_
6	the Fire	Modical	(Check only 1 Certifying I one) 2 Medical Ex	e nysician : To the basi aminer:On the basi and manner	s of examination	and/or investig	ation, in my	opinion, de	ath occurred	d at the time, d	ate and pl	ace, and due to	the cause(s)	
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			() aun	erleant	<i>)</i>			O.C.M.E	=. 		NO.	vember 20,	2009	_
_			30. Name and address of person Laron Locke MD.	on who completed ca Assistant Medic		_{em 23a)} - 111 Pen	ın Street,	Baltimo	re, MD 2°	1201				
		Star	Or Data filed (M. H. D. C.)		Registrar's Sign		41							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item I per doc 8897 11-23-09 Mental Hygiene

			1 - For State Registrar	State of M	laryland /		ያየቸጥėnt ôfች <i>tificate of l</i>		d Mental I		2009	37404
. 41			1. Decedent's Name (First, Mid	dle, Last) Glenn	Knight				2. Date of	Death		3. Time of Death
	Physic /Med		Glenn			K	right		Noven	nber 16		2:04 A M
37	Exami		4a. Facility Name (If not instituti				4b City, Town, or	r Location of De			County of Death	
			The Johns Hopkin 5. Social Security Number				Baltimore					
Н	Funeral Director			6. Sex 7. A	ge (In yrs. last b 45	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours M		Day, Year)	Couri	place (State or Foreign try)
	ъ		214-84-0259 Usual Residence of Decedent		45				09	23 6	4	MD
	ırylan show	_	10a. State 10b. Coun	y	10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	he Ma 28a-f	Director	MD	NA	1	Bal	cimore					Y☐ Yes 2 ☐ No
	with t				. ".	_	10f. Zip-Code			10g. Citize	en of What Cour	•
	heath ns 23 must	Funeral	1300 East La	12. Was Decedent		_		21213	(Specify Voc or	No. 1	U.S.	
215-0036	be filed within 72 hours after death with the Maryland that Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4X Divorce	Armed Forces	?		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 【XNo	Specify:	erto Rican, etc.)		Black, White,	
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Maryland	e d la la la la la la la la la la la la la	Be		,					Name (First, Mio	,	Surname)	
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	12 h a 7 is		Bryant Knigh	, , , ,			rowood					
re,	_ 7 5 5		20a. Method of Disposition		20b. Place of	of Dispos	sition (Name of atory or other place	-	Date		ation - City or To	
Ē	Pages nent of int: If i		M□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (1		norial E		1/20/0	9 Wood	dlawn.	MD
Baltimore,	permit. Pages 1 Department of the Important: If ite any injury or ot once.		21. Si per die of Funeral Service	Licensee)	22	Name and Addres	s of Facility	_,, _			
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			23a. Part . Enter the disease, o shoo, or heart failure. List	only one cause on each iir	i the death. Do	not ente				y arrest,		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate use (Final disease of an indition resulting in death)	a molti	syster		organ.	failure	2			Onset and Death
4	Examiner		,	Due to (or as	a c dequence	of):	0	•	,			
		ner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):						
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6	ificate be executed physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):						
58760,	cate b	Physician/Medical		d								
		J/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							
Box	The law requires that the death certine the has been signed by the attending page 2 should be detached for use a	iciai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death		Ectopic pregnancy Other (specify)			230	 d. Date of delive Month 	ry Day Year
o	the d y the achec	hys	9 Unknown	9 🗌 Unknown								
ν. σ.	es that gned b be det	by F	Part II. Other significant conditi	ons contributing to death b	ut not resulting	in the ur	derlying cause giv	en in Part I.	23e. Di	d tobacco use	contribute to th	e cause of death?
ord Ord	law require as been sig 2 should b								_ 1[Yes 2	No 3 🗌 Proba	ıbly 4 ☐ Unknown
Vital Records,	has bei ge 2 sh	Completed							24a. Wa	s an opsy		sy findings available
									1 Ves	formed?	death? 1 🗌 Yes	2 No
<u>₹</u>	sician: The certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Other		eath (Check only			
ō	皇 三 一	6	1 Yes 2 No 27. Manner of Death	1 Inpatie		tpatient Time of	3 DOA Other	4 🗆 Nursing		sidence 6 a	Other (Specify)	
on	tter ding P death. tor After t	atior	1 ✓ Natural 5 ☐ Pendir 2 ☐ Accident investi	q (Month, Day		njury	Work?	es 2 🗆 No	200. Describ	e now injury o	iccurred	
Division of	r Atter a er dea Director I n by th	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ry - At home, fai	rm, stree					Number or Rural	Route Number,
		Cert		*						own, State)		
:	To the Hospital or within 24 hours a e To the Funeral Diru completely filled in	edical	29a. Certifier (check only one) 1 Certifylr 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination and	, death o d/or inve	occurred at the time stigation, in my op	e, date and pla- inion, death oc	ce, and due to the curred at the time	ne cause(s) ar e, date and p	nd manner as sta lace, and due to	ated. the cause(s)
: 	Vithi To th		29b. Signature and title of certifie	11.1.			29c. License	_		29d. Date s	igned (Month, D	ay, Year)
			1. G.				RES	5 000		Nover	nber 16	2009
			30. Nam and address of erson	who completed cause of d	eath (Item 23a)	(Type, P	rint)					
	Sta		Jereniah Geo H 31. Date filed (Month, Day, Year)	32 Aegistra	's Signature	<u> </u>		600	North W	olfe St,	Baltimore	e, MD, 21287
	Registra	~	NOV 23	2009 January	s signature	40	Kal					

Physician /Medical Examiner

Funeral Director

Director

Funeral

show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at within 72 hours after 12 should be filed w h and Mental Hygie 7 is marked other t

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Pages 1 and 2 sl ment of Health an ant: If item 27 is

or Attending Physician: The law requires that the death certificate be executed burial-trai physiciar as the nse for the signed by g has been this certificate filled in by the funeral after death.

Division of Vital Records, P.O. Box 68760,

the Hospital

permit. Pages 1 Department of I Important: If ite any injury or ot Examiner Physician/Medical Completed by Be ٩ Certification: To the Hospital within 24 hours a To the Funeral C completely filled

1. Decedent's Name (First, Middle, Last) 3. Time of Death Sr. Francis Helen Lewandowski 17, 2009 November 10:43 ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1525 Marriottsville Road Marriottsville Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 02-28-1909 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🏲 F 266-06-5402 Mary Land 100 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Marriottsville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 Marriottsville Road 21104 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 □Yes 2 X No à Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anton Lewandowski Catherine Peska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Talone/ Friend 1525 Marriottsville Rd., Marriottsville MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 11/20/2009 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Si nati re of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metostatic Breast Carcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown tens10 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗹 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

State Registrar

CHIVE IT HAV THOUT

31. Date filed (Month, Day, Year)

salalued den

29b. Signature and title of certifier



MD

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



D. Salahuddin 20 Crossroad Drive, Suite 101 Owings Mills MD 21117

29c. License number

D20252

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2009 37406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OYIS 2:00/AM 19,200 Vovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner izabeth VUrsing a timore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Aug 22, 9. Birthplace (State or Foreign 7. Age. (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Min Year) 18 Mary land 212 09 3057 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Physical Examiner man be rediffed at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2 No Director Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3320 Benson Ave. 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give Year or Dates Completed by Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Pharmac List Assistant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy 17. Father's Name (First, Middle, Last) Joseph Grisbach 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Fenwick ည 19a. Informant's Name/Relationship (Type. Print)
Domena C. LaPaglia-Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 Benson Ave. Apt 407 Baltimore, Md 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Cathedral 11/23/2009 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Sterling-Ashton-Schwab-WitzkeF/H 1630 Edmondson Ave. Catonsville, Md 21228 Inc. 21. Signature of Euneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumon une week /Medical Examiner ement eins Sequentially list conditions, any, the fine 1. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequen Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Day Year 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ en5100 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed nemia 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes ∠No 24a. Was an autopsy History uterine 0 + 1 ☐Yes 2 ANo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Other: Medical Certification: To 4M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 | Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cau e death (Item 23a) (Type, Print) 3320 Benson Baltimore. Maryland MD Wing 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MYERS Month 2009 SIDNEY NOVEMBER 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Hospital Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 □ M 2 1 F Months Days Hours 214-36-9491 Jan 11 1939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carrol1 Sykesville 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 767 Central Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nursing assistant health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Myers Sidney Elaine Snowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Myers (daughter) 767 Central Ave., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation: 11-23-09 Sykesville, MD 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dury Harget Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCINOMH Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year □Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 □ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760, signed by the attending to be detached for use Division of Vital Records,

To the Hospital or Attending Physician:

Physician

/Medical

10a. State

Director

Completed by Funeral

Be

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MD

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene. and the first and Mertal Hygiene. and the first 27 is marked other than "natural", or items 23a or 28a-f show any of items and ite should be an any or other traumatic event, Ite Maryland Experiment has notified at

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Exami Physician/Medical 2 Completed within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag. ပ Certification:

25. Was case referred to medical examiner? 2 No 1∐ Yes 27. Manner of Death Natural 2 Accident 5 Pending investigation

1 Inpatient Date of Injury (Month, Day, Year) 6 Could not be determined

28b. Time of 28c. Injury at Work? ₃1 🗆 Yes 2 🗆 No 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

30. Name

3 Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signatur and title of certifier

D42783

2009 MOVEMBER

AVVERAHALLI

HARISH

of person who completed cause of death (Item 23a) (Type, Print) NOFTH WEST HOSVITH, COUNT ROAD 5401 OLD

State Registrar

Medical

31. Date filed (Month, Day, Year)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 5:348M Joseph Gordon Marsh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Center Glen Burnie Baltimore Washington Med. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Feb. 13 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** - 1<u>934</u> 1 🛛 M 2 🗆 F Mary Land Director 216-30-8169 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f 1 Yes 2X No Pasadena Maryland | Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral United States 21122 8226 Fairwood Dr. or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Tool & Dye Maker Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be Hilda Lewis Guv Gordon Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Pasadena, MD 21122 8226 Fairwood Dr. Mary Patricia Marsh / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 2 Cremation 3 Removal from State Nov. 25, 2009 Donation 5 Other (Specify) Baltimore, Maryland Woodlawn Cemetery tre of Funeral Servi 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, MD Signa Licensee 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ In forctur disease or condition resulting in death) Medical Due to (or) as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a 9 . Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed 1 Yes. 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my animal data. Medical 29a. Certifier сопретер The certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 63226 1406 crain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10005 Burni Many land

State Registrar 31. Date filed (Month, Day, Year)

3. Registrar's Signature_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH 8898 12/9/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ronald **Physician** George Martin 20:21 NOVEMBER 200° /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA BALTIMORE ST. AGNES HOSPITAL 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Sex. 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours MD 220.64.930 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madeal Eventual court to a cultural at 1 XYes 2 ☐ No MD Baltimone Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number North Hill Road 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)
COOTAINATOR OF SPECIALIS 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of State and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Specialist maryland Programs 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be segrae Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town), State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Balttmore, MD 21215 Dennlyn Road Melvin T. Lee 120ther Date UNK 20c. Location - City or Town, State 20b. Place of Disposition (Name of W) cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Battimore, MD 12/10/09 Cedar Hill Cemetery 22. Name and Address of Facility Vaughn C. Greene Funcing S/CS 8728 Liberty Foad Randaulotony) MD 21133 21. Signature of Funeral Service Licensee Variet Approximate Interval Between Onset and Death 23a. Part 1. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-transi Due to (or as a consequence of) pe Physician/Medical attending property for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? AIDS 24a. Was an certificate has b irector, page 2 st MARTIN, RONALI autopsy perform 2 No 2 No 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND 908 CATON TANEY Registrar's Signature State Registrar

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		•	For State Registrar		Certificate of De		Reg. No	-711110	37410
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	Jaddy Late	nia McFadde		ate of Death Ionth Da	14 EDD	3 Time of Death 11:55pm 72:307.
-	Examin		4a. Facility Name (it not institution, give str	eet and number) Jerrace	4b. City, Town, or Lo	ocation of Death	40	c. County of Deat	h
	Funeral Director		812 0 0 0000	M 2 197 7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. 8. D. Hours Min. (A	ate of Birth lonth, Day, Year)	ca Co	thplace (State or Foreign untry)
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o		9,	/23/1969		10d. Inside City Limits 1 Yes 2 □ No
	the Mar or 28a- e notifi	Funeral Director	10e. Street and Number	- Dal-	10f. Zip Code		10g. C	itizen of What Co	
	ath with	unera		Lerrace. 2. Was Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Specify Yo	es or No-	USH 14. Race - Ame	rican Indian.
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	Completed by F	1 ★ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.	If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	Mexican, Puerto Rican,	etc.)	Black, White	
215-0036	י 72 hou an "natu Medica	mplet	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		ecedent's Usual Occupati jive kind of work done dur e. DO NOT use retired		11/1	Kind of Business	
21	filed withir al Hygiene d other th went, the	Be Co	17. Father's Name (First, Middle, Last)	College (1-4 of 5+)	- 1	18. Modified S Name (Firs	t, Middle, Maiden	rizon	<u>Wireless</u>
Maryland	should be filed within 7: n and Mental Hygiene. 7 is marked other than raumatic event, the Me	Tof	T I AA I	ammed		Nlarga		Tad	den
	and 2 shou Health and tem 27 is m		194 Informant's Nanje)Relationship (Type Shaki a Yarker (7 -	Mailing Address (Street and 34 TOPICA)	1 4	alto.	m D 21	216 216
Baltimore,	Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		hisposition (Name of crematory prother place)	y 11 19	09 Ba	ocation - City or	1000
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	Hacero.	22. National Address	offaility Gree	re Fur	eral S 21279	ervices
			23a. Part 1. Enter til disease, or complic shock, or hear failure. List only one	cause on each line.			iratory arrest,		Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)	ian Can	icek			3 years,
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)					
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Hoo 9 □ Unknown	c. If yes, outcome of pregnancy 1	3			23d. Date of de Month	livery Day Year
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of Vital Records,	v require s been si should	Completed by	- suronna q	- sigly		<u> </u>	24a. Was an	24b. Were au	topsy findings available
Rec	: The lav cate has page 2	Comp					autopsy performed? 1 Yes 2 200	death?	completion of cause of
Vital	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 DNo	spital: 1 ☐ Inpatient 2 ☐ ER/Outp	Other:	e of Death (Check only 4 Nursing Home 5		6 ☐ Other (Spec	
n of	Attending Ph death. ctor: After thi y the funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tin	ne of 28c. Injury a work?		Describe how inju		
Division	I or Atten safter deat Director: d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. L	ocation (Street ar		ral Route Number,
	le Hospite n 24 hours le Funeral	Medical	(Check 2 Medical Examine)	an: To the best of my knowledge, de r: On the basis of examination and/or i Practioner/To the best/or my knowled	nvestigation, in my opinion,	, death occurred at the til	me, date and plac	e, and due to the	cause(s) and manner stated.
	vithi com		29b. Signature and tipe of certifier	Tust I	29c. License n			ate signed (Mont)	
	P		30. Name and address of person who com	1 22 7St Pall	l Place,	069848 Balkm	ore M.	0 212	02
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Signature	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedents Name (First, Middle, Last) 2. Date of Death **Physician** Month AMELA MANGUM Novembo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death Randallstown 4c. County of Death Examiner Season's Hospice @ Northwest Baltimore Hospital
Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 😾 F 217-74-0600 Director 1958 Maryland Aug. 11. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examinating to notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Y☐Yes 2☐No Maryland Baltimore N/A 10e: Street and Number 10f. Zip Code 21215 10g. Citizen of What Country? USA 2604 Springhill Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. Black 1 ☐ Yes X☐ No 9 Specify. 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Self Employed College (1-4or 5+) Years Care Provider 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Annie P. Mangum Richard Brooks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 21215 5430 Park Heights Ave Baltimore, Maryland Annie P. Ford /Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/09Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 21. Signature Funeral Service Licens 22. Name and Address of FaciliChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final [⊉]Physician Immediate Cause (indisease or condition resulting in death) 1479 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and buriat-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 2 No 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)
Other: 4 □ Nursing Home 5 □ Residence 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

State Registrar 29b. Signature and title of cer

30. Name and address of person

31. Date filed (Month

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Manth, Day, Year)

			For State Registrar	State of	f Marylar		rtment of F	lealth and M	-	-		
	Physic		1. Decedent's Name (First, Middle,	Last) umford			imouto or	<i></i>	2. Date of Dea	Beg. No. 2 (ath ber 19,	109 2009	3. Time of Death 3:45 P M
4	/Med		4a. Facility Name (If not institution,		nber)		4b. City, Town, o	r Location of Death	NOVEIII	4c. Count		3.43 F ***
1	- ^		Renaissance Gai			Village					imore	
	Funera Directo		415-62-2488	Sex 1 □ M 2 X F	7. Age <i>(In yrs.</i> 74	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 1.	h y, Year) 3,1935	Coun	lace (State or Foreign try) ISSIPPI
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	eation				11	Od. Inside City Limits
	Maryl F sho	tor	Maryland Baltii	none		rkville	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1 □ Yes 2 No
	h the	irec	10e. Street and Number	nor e	rur	KVIIIE	10f. Zip Code			10g. Citizen of	What Coun	try?
	th wit	ra 🗆	8832 Walther Bl	d, RGS	326		21234			USA		
	er dez items	Funeral Director	11. Marital Status	12. Was Dece Armed For	ces?	l.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra Bla	ce - America	
	D36	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, Giv Year or Da	e	1	□Yes 2□XNo	Specify:		Specia	y: Wh	iite
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Markel Examiner must be redified at	Completed by	15. Decedent's	 Education		16a. Deced	ent's Usual Occup	ation		16b. Kind of B	usiness/Ind	ustry
	21; Ithin 7 ne.	nple	(Specify only highest (Elementary/Secondary (0-12)	College (1-	4or 5+)	life. D	and of work done of NOT use retired	during most of worki d)	ng			
	led with the the	ပိ	47 Falls of News (First Middle La	4		Tea	cher		(-	Educe		
	and d be fi ental H sed ot	Be C	17. Father's Name (First, Middle, La John Taylor Lo	1				18. Mother's Name Vivian	McLaur		ne)	
	should Me Merk	2	19a. Informant's Name/Relationship			19b. Mailin	Address (Street	and Number or Rura			State Zin	Code)
	and 2: lealth a m 27 is her trau		Tracey Gillman/			585 I	Peck Rd.	Downing	town,			
3:45pm	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be rediffed at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		itate Mo	Place of Dispos cemetery, crem ney &	ition (Name of atory or other place KING	e) Nov.	24,200	20c. Location		1~
4	altii mit. F partm sortar / injur		21. Signatury of Funeral Service Lic	anego 4	Cr	remation	Name and Address	ss of Facility MC	onev &	Kina F	unera	Home.
w	B B B B B		HOUR SOULS	CC0	, ,,,,,,,,	wner	171 W. /	Maple Ave	., Vier	nna, Vo	i. 221	80
0 60/6	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. ather		obi Ca		g, such as cardiac c		rest,		Approximate Interval Between Onset and Death
1/11	0 10	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a conseq	uence of):						
4	68760, ficate be executed physician and s the burial-transit	I Examiner	that initiated events resulting in death) Last	c	r as a conseq	uence of):						
ND	68760, fificate be ex	edical		d								
, GLE	Box (ath certification of use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 🗖 Feta ant at time of c	l déath 3 🗆	Ectopic pregnancy Other (specify)	/			ite of deliver	ry Day Year
MUMFORD	ds, P.O.	H.	Part II. Other significant conditions	contributing to dea	ath but not resi	ulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to the	e cause of death?
170	rds quires n sigr	d by	T20M. Cardio						1 □ Y	es 2 No	3 Proba	ably 4 🔲 Unknown
3	ecord law requir as been s 2 should	Completed))			-		24a. Was a	an 24b.	Were autop	sy findings available
3	I Re	NE N							autop: perfor	med? 🖊 📗	prior to com death? 1 □Yes	sy findings available apletion of cause of
	of Vital F hysician: Th his certificate I director, pag	BB	25. Was case referred to medical examiner?					26. Place of Death			TILITES A	2 110
	Of V		1☐ Yes 2☐ No	-		ER/Outpatient		Nursing Hor	ne 5□ Resid	ence 6 □Oth	ner (Specify)
	on of ding Ph h. After th funeral	ion:	27. Manner of Death Natural 5 ☐ Pending	,	f Injury r, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occur	red	
	Division of Vital Records, to Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be dien by	Certification: To	2 Accident investigation 3 Suicide 6 Could not determine	00	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, office	/es 2 □No	28f. Location (S City or Tow	treet and Numb n, State)	per or Rural	Route Number,
A	Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical Ce	29a. Certifier (Check only one) 1 Certifying F	hysician: To the base and manner	sis of examina	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ded at the time, d	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
5	To the within To the Comp	Me	29b. Signature and title of certifier	an		RMP1 MSN	29c, License	number 944	2	29d. Date signe	d (Month, E	Day, Year)
			30. Name and address of person who		of death (Item	1 23a) (Type, P	rint)			1111	1	
	Sta	ate	Micheale G. Harri 31. Date filed (Month, Day, Year)		8632 gistrar's Signa	Walther	Blvd, Par	Krille Mo	21234			
			MAN A - COOL		. A	17.0						

DHMH 17 Rev 1/2001

To the Funeral Director:

30. Name and address of person who completed cause of death (Item 23a) R Margarita Korell MD. 31. Date filed (Month State Registrar

29b. Signature and title of certifier

Vanjour

Assistant Medical Examiner

and manner stated.

me Inell

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 15, 2009

Sammie Lee McCullough

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 374 14

		1- For State Registrar		Certific	ate of	Death			Re	g. No.		
Physicia	_	1. Decedent's Name (First, Middle	e,Last)						Date of Death			3. Time of Death
Medical Exami	ner	Sammie	Le	e	Mo	Cullou	gh Jr	r. N		Day 14, 2009	ear	0129 hrs
		4a. Facility Name (if not institution University Hospital	n, give street and nui	mber)	4	b. City, Town, or I Baltimore	Location of E	Death		4c. Count	y of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bir	rthday)	If Under 1 Year	If Under 2	24Hrs. 8.	Date of Birt	h(MM/DD/YY		hplace (State or
Director		215-86-2042	1 X M 2 F	36	Yrs.	Months Days	Hours	Min.	0 7 C	8 73	Foreig Cou	n untry) MD
è	ŀ	Usual Residence of Decedent 10a. State 10b. County	-	10c. City. Towr	or Locatio	nn.			_		- 1	10d. Inside City Limits
faryland 28a-f show any 1 at once.	ъ		NA		altin							1 X Yes 2 No
faryland 28a-f sho 1 at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Cour	try?
the N		3811 Parkmon	t Ave			21	206			U	.S.A	i •
with ns 23 be ng	교	11. Marital Status		edent Ever in U.S.		Decedent of His						can Indian, Black,
15-0036 filed within 72 hours after death with the Maryland Hygiene. of other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	/ Funeral	Never Married 2 XMa Widowed 4 Dive	1 Yes	2 X No		s, specify Cuban, Yes 2 X No		uerto Rica	in, etc.)	Specify	eite, etc. $oldsymbol{eta}$.ack
urs af tural	호	15. Decedent's Education (Spec	or Dates: cify only highest grad	e completed) 16a.		s Usual Occupati		nd of work	done	16b. Kind of I	Business/Ir	ndustry
5-0036 ed within 72 hours a lygiene. other than "natural	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during mo	st of working life.	DO NOT us	se retired)		Movin	g an	ıd
D36 thin ne.	ם	12th grade	na			Owner				Hauli	na C	Company
5-00; lled with Hygiene I other th	ैं।	17. Father's Name (First, Middle,					8.Mother's	Name (Fire	st, Middle, M	laiden Surnan		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	å	Sammie L. McC 19a. Informant's Name/Relationsl	ullough	Sr.			Mylir	nda 1	Weave	r		NAMES OF THE OWN
21 Dould The Me of Me is ma	입					Address (Street						
MD nd 2 sho alth and m 27 is aumati		Vemete McCul	lough-Wi			Parkmo						
		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fro		of Disposit story or other Law i	ion (Name of cen er place)	netery,	Da	te	20c. Location	n - City or	Fown, State
Page Page nent c		4 Donation 5 Other Sp		King	Mem	rial P	ark	11/	21/09	Woo	dlaw	n, Mđ
Saltimore, permit. Pages I ar Department of Her mportant: If ite njury or other tr	1	21. Signature of Foneral Service	Licensee)	22. Na Mar	me and Address	of Facility West	t.				
	- 3	Vinetto	L'ymes		430	<u>)O Waba</u>	sh At	ve,	Balti	more,	Md	
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		used the death. Do r	not enter the	e mode of dying,	such as card	diac or res	piratory arre	st, shock, or h	eart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease		ound of Chest								Death
Armen and a second	- 1	or condition resulting in death)	Due to (or as a	consequence of):								
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):								
	튑	cause. Enter Underlying Cause (Disease or injury that initiated	С.									
to be executed ysician and burial - transit	I Examiner	events resulting in death) Last	Due to (or as a	consequence of):								
3760, ficate be executed g physician and s the burial - transi	n/Medical	UNPENDED	X AMENDED	l,per me	, 20ъ	per fh	g897	11-2	23-09	vt		
9 8 6.8	Me	IF FEMALE:		outcome of pregnancy			7			23d. Date	of delivery	
687 certifi	ian	23b. Was decedent pregnant in th past 12 months?	December 1				Ectopic p	regnancy		Month	D	ay Year
Box 687 ne death certific the attending perfection and for use as the	Physicia	1 Yes 2 No 9 Unk	nown 9 Unkno		5 Oth	er (Specify)						
C. He d	윤	Part II. Other significant conditi			ng in the ur	derlying cause g	iven in Part I	i.	23e. Did tol	pacco use cor	tribute to t	the cause of death?
P.O. res that the signed by be detached	ğ								1 Yes	2 🗸 No	3 Prob	abiy 4 Unknown
ords, w require is been si should t	Completed by					100		- 4	24a. Was a			topsy findings available
COF law r has b	ם			_				<u> </u>	autops perfori		prior to c death?	ompletion of cause of
tal Recian: The certificate	Ö								1 Y Yes 2	No No	1 🗸 Ye	s 2 No
Vital Rec ysician: The his certificate director, page	B	25. Was case referred to medical examiner?		_			of Death (Ch					
f Vi Physi ral dir	ျ	1 Yes 2 No 27. Manner of Death	Hospital: 1 🗸 II		Outpatient	obon		Nursing Ho		Residence 6	Li	
Division of Vital Records, ral or Attending Physician: The law requir rs after death. al Director: After this certificate has been sied in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	Certification:	1 Natural 5 Pend	ling 28a. Date (Month, Nov 14,	Day Year) 2009 004	Time of In		y at Work? es 2 ✔ No	Sub	ject was	ow injury occu shot	irrea	
ViSi or Att ter de hirect in by	fica			e of Injury - At home, t	farm, street	, factory, office be	uilding, etc.	28f.			ber or Ru	ral Route Number, City
Divospital of hours af hours af uneral Divospital Divos	e.			Local Street				2400	or Town, St 0 Block Dr	^{ate)} uid Hill Aver	ıue, Baltiı	more, MD
* = 4 = 5	Medical C	29a. Certifier 1 Certifying Prone) 2 Medical Example 1	nysician: To the bes miner:On the basis o	t of my knowledge, de of examination and/or	eath occurre	ed at the time, da	te and place death occur	e, and due rred at the	to the cause	e(s) and mann and place, and	er as state I due to the	ed. e cause(s)
To the comple	i i	29b. Signature and title of certifie	and manner st	ated.		29c. License						nth, Day, Year)
			111			O.C.N				Novembe		
		- YV	VVI.	0.06 d0.011 /11							,0	
		30. Name and address of erson Jack Titus MD. Dep	who completed caus outy Chief Medic			n Street, Balt	imore, MI	D 21201	1			3
St Regist	ate trar	31. Date filed (Month, Day, Year)	0000	gistrar's Signature	park							
	_	- FUT-60	- Paris									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Lee Martin 2009 4:04p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 08 25 (Month, Day, Year) Country) Director 225-12-1580 VA 96 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD NA Baltimore 1 🛚 Yes 2 🗆 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 3913 Oakford Ave U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sparrow Point 9th grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Ruth Morris Phil Martin Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 3513 West Forest Park Ave, Baltimore, Carl Martin-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 11/21/09 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature of Funeral Service icensee Ave, 21215 Baltimore, Md Approximate Interval Between 23a. Part 1 Enter the disease, or complications that caused the death. Do no enter the mode of dying, such as cardiac or respiratory arrest, shoc or heart failure. List only one cause on each line. Immediat Cause (Final disease of wondition Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dire to for as a punsiculing offi-Exami signed by the attending physician and dedetached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by Records, 1 Yes 2 No 3 Probably 4 2 nknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an The law has autopsy Yes 2 Physician: filled in by the funeral director, Vital Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **1** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this of 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 31. Date filed (Month, Day 's Signati State

DHMH 17 Rev 7/2009

Registrar

Sm

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		1 - State Registrar		Cei	rtificate of	Death		Reg. No.	2009	37416
Dhyoisi		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
Physici / /Medic		ROYSTER GEORGE	NORWOOD				NOV	16	2009	9:45a [™]
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deatl	1	4c. (County of Death	
		4727 Bromley Ave.			Suit1	and		Pr	ince Geo	rges
Funeral		5. Social Security Number 6. Se		**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av, Year)	9. Birthp	lace (State or Foreign
Director		237-36-8053	81 81	Yrs.	monaro Dayo	, riodio	May 5,	1928	NO	
pu »		Usual Residence of Decedent 10a. State 10b. County	100 Cib.	Town or Lo	antion				1	0d. Inside City Limits
aryia shov	<u>_</u>	Toa. State Tob. County		, Town or Lo					'	1 ☐ Yes 2X No
Ba-f	Director	MD Prince Ge	orges Su	itland						
ith th	Öire	10e. Street and Number			10f, Zip Code			10g. Citiz	zen of What Coun	try?
ath w	Funeral	4727 Bromley Ave.			2074	<u> </u>			USA	
tems	une	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. \	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	0- 1	 Race - Americ Black, White, 	
g affe	by F	1 Never Married 2 Married	1 ∐Yes 2 to No If Yes, Give		1 □Yes 2 X No	Specify:		-	Specify:	
ural'		3 XWidowed 4 Divorced	Ye ar or Dates:	10 0		.,			BLa	
"nat	lete	15. Decedent's Edu (Specify only highest grad	e completed)	Give	dent's Usual Occup kind of work done	oation during most of woi d)	king	16b. Kir	nd of Business/Inc	dustry
withir sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		iture Fi			c/	anra Dan	t. Stores
Hygic Hygir Int, III		11th 17. Father's Name (First, Middle, Last)		rulli	Tture FI	18. Mother's Nar	no (First Middle			t. Stores
ntal led o	Be	,							Samanne)	
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked other than "natural", or Items 23a or 28a-f show umatic event, it will death and it will be notified at	ဠ	Henry U. NOrwood					se Bann			
h and h and		19a. Informant's Name/Relationship (T)	•		-	and Number or Ri		-		Code)
1 and 2 Health a Health a sem 27 is		Cornelia N. Dobbi			Merritt				D. 20747	
Pages 1 nent of H unt: If Ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	ace of Dispo emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or To	wn, State
. Pa tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)			n Nation		24-2009		tland, M	D.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the midden Exat. In a nat be notified at once.		21. Signature of Euneral Service Licens		n Mi	alamhand Addre	ss funeral	Home o	f Mai	ryland	
1 205 20		Chelerinol	Woods		308 Suit		Suitla	ınd, 1	Md. 2074	6
		23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused the death	. Do not ent	er the mode of dyi	ng, such as cardia	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Coronary Art	terv D	isease					Onset and Death
/Medical		resulting in death)	a							
Examiner			Hypertension	n						
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ							
outec d ansit	Examiner	Cause (Disease or injury that initiated events Diabetes Mellitus								
exection and an and and and and and and and and	Exa	resulting in death) Last	Due to (or as a consequ	ence of):			•			
ficate be executed physician and sthe burial-transit	g		d							
	Medical									
0 = 0		IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome of <u>p</u> regna	ncy _					23d. Date of delive	erv
death atte	sician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су			Month	Day Year
the check	ysi	9 Unknown	9 Unknown							
Attending Physician: The law requires that the death redest After this certificate has been signed by the attered tirector, page 2 should be detached for up	y Phy	Part II. Other significant conditions co	ntributing to death but not resu	iting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
uires uires Id be	d by	Cerebrovascular A	ccident				1 🗆	Yes 25	No 3□ Prol	oably 4 🗌 Unknown
w require b been si should b	Completed						04-114-		045 144	
: The law cate has I	ם						24a. Was	opsy formed?	prior to co death?	psy findings available mpletion of cause of
n: The								2 🔯 No	1 □ Yes	2 🗆 No
hysician: The his certificate I	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of De				
Thys aldiis	£	IL res 21X000	¹ 1 ☐ Inpatient 2 ☐		IL 3 DOA				Other (Special	fy)
dlng Ph h. After th funeral	ion	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wo		28d. Describe	how injury	y occurred	
teath for: the t	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2∏No				
or All	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, tarm, str ')	eet, tactory, office		28t. Location City or To	(Street and own, State)	d Number or Rura)	al Houte Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fun		20 0 17	1							
Hosp 24 ho Fune tely fi	Medical	(Check only 2 Medical Exam	rsician: To the best of my knowiner: On the basis of examinat							
the I hin 2 the I nplet	led	one)	and manner stated.							
5 With 50	2	29b. Signature and title of certifier	n n. o		29c. Licen:	se number		29d. Dat	e signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7611 S. Osborne

2. Registrar's Signature

Imelda Miranda, MD

31. Date filed (Month, Day, Year)

D43276

Suite 106 Upper Marlboro, MD.

11/18/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Nov. 16, ^{Day}2009 Physician Barbara Mae Nixon B:08p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A 3503 Dorchester Rd Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 18, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Year) 930 Mary Tand 1 ☐ M 2 🖵 F 78 Vrs 214-26-2121 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Maryland N/A Baltimore Director 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 3503 Dorchester Rd. 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Completed by Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 C&P Telephone Co. Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Clay Lillian ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Bolton St., Apt. 312, Baltimore, MD 21201 Donna Jones-Coward (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 11/21/09 Baltimore, Marvland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Fig. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, such as cardiac or respiratory arrest, the mode of dying, are the mode of dying arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory arrest, the mode of dying are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory are cardiac or respiratory a Approximate Interval Between Anset and Death Immediate Cause (Final MONTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine untercause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Funerai 29a. Certifie Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check o Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the I b. Signature 29c. License number 29d. Date signed (Month. Day. Year) 18,2007 MD coause of death (Item 23a) (Type, Print) Name and address of person w MITS IAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2009 'Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

Division of Vital Records,

Registrar DHMH 17 Rev 1/2001

State

1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Raymond Maclane Proutt

ORIGINAL

37418

2. Date of Death November 19, 2009 2:30 P

Certificate of Death

4c. County of Death

Anne Arundel

8. Date of Birth (Month, Day, Year) Feb. 2, 1 Birthplace (State or Foreign Country) Maryland 1942

10d. Inside City Limits 1 ☐Yes 2 No

10g. Citizen of What Country?

United States Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Self-Employed 18. Mother's Name (First, Middle, Maiden Surname)

1249 Indian Landing Rd., Millersville, MD 21108 20c. Location - City or Town, State

Catonsville, Maryland

Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Approximate Interval Between Onset and Death

23e. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown

23d. Date of delivery

24a. Was an autopsy performe 1 ☐Yes 2 XNo

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

Day

Year

00

Other: 4 Nursing Home 5 Aresidence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

November 20, 2009

Russell R. DeLuca, M.D., 305 Hospital Drive, Glen Burnie, Maryland 21061

31. Date filed (Month, Day, Year) Registrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009

1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 19, 2009 **Physician** Alice T. Parker 3:17 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Health & Rehab. Anne Arundel Center Glen Burnie 8. Date of Birth (Month, Day, Year)
Sept. 10, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 🗓 F 1922 Maryland 87 Director 215-18-3284 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examin or must be rediffied at once. 1 ☐Yes 2 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1323 Meadowvale Rd. 21060 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 If Yes. Give Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. McCracken Alice T. Higdon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 Magothy Bridge Rd., Pasadena, Maryland 21122 Carroll E. Parker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 23, 20a. Method of Disposition 1 ABuria! 2 ☐ Cremation 3 ☐ Removal from State 2009 Elkridge, Maryland Meadowridge Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signature of Force I Service icensee 9 21061 Approximate Interval Between Onset and Death 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE **Physician** ALZHEIMER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificete be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 🖾 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☑ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ∐Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Çertifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific en, IMM. D17753 November 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 Potee St., Suite 5, Baltimore, Maryland 21225 Kurupp Dharmasena, M.D., 31. Date filed (Month Day, Year) State rail Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	for State of Maryla State of Maryla Registrar		rtificate of L		Re	g. No. 200	9 37420	
	Dhuaiais		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Patricia May Rotundo				Nov. 2	1, 2009 4c. County of De	6:00P M	
4	Examin	er	4a. Facility Name (If not institution, give street and number)		•	Location of Death		Baltimo		
			Heritage Nursing Home 5. Social Security Number 6. Sex 7. Age (In)	eyrs. last birthday)	Dundal If Under 1 Year	K. If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)	
71	Funeral Director		214-50-6001 1 M 2X F 61	Yrs.	Months Days	Hours Min.	(Month, Day, 8-29-1		MD	
	p.		Usual Residence of Decedent	City, Town or Lo	antion				10d. Inside City Limits	
	arylar show	_		Baltimo					1 □Yes 2 🛣 No	
	ne Ma 28a-f	Director	MD Bazezmer		10f. Zip Code		10	og, Citizen of What (Country?	
	a or 2	ă	100. Street and Number		21220			USA		
	eath	Funeral	132 Lariat Road 11. Marital Status 12. Was Decedent Ever i	n U.S. 13. 1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		nerican Indian,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Medical Evander traumatic event, its Medical Evander traumatic event, its Medical Evander.	by Fun	Armed Forces? 1 □ Never Married 2 □ ★ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 □ ★ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 🛣 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	_{iite, etc.} White	
21215-0036	n 72 hou "natura edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work ')		16b. Kind of Busines	ss/Industry	
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b	il Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam		faiden Surname)		
au	Mental Mental arked o	TO B	Milton Wolley				Hobbs			
ary	2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (Type. Print)					City or Town, State		
Σ,	and 2 ealth n 27		Michael Rotundo - Husban	d 132	Lariat	Road, B	Baltimon	ce, MD 2	r Town State	
Baltimore, Maryland	Z = E			Holly 1	osition (Name of matory or other place Hill Cen	n. 11-2	25-09	Middle R	iver, MD	
Balt	permit. P Departm Importar any inju		21. Signature of Funeral Service Licensee	2	PA, 2134	ss of Facility Br Willow	adley-1	Ashton F g Road,	uneral Home 21222	
68760,	Physician / Medical Examiner st the purial-transit	dical Examiner	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	A-TORY asequence of: A-TEN S asequence of): A-YRO asequence of):	FAIL VON DISMY	URE			Interval Between Onset and Death
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of Vital Records,	n: The law req ficate has beer n, page 2 shou	Completed	Of Weather referred to refine			as Place et les	24a. Was a autops perfor 1 □ Yes	prior deat	e autopsy findings available to completion of cause of 17 res 2 DNo	
₹	Physician: r this certific ral director, I	Be c	25. Was case referred t edical examiner? 1 ☐ Yes 2 ☑ Yo Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Oth	nar:		ence 6 Other (Specify)	
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Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office	-	28f. Location (S City or Tow	treet and Number on, State)	r Rural Route Number,	
	e Hospital 24 hours a e Funeral I letely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	y knowledge, dea amination and/or i	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time, o	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
	To the h within 2. To the f complet	Mec	29b. Signature and title of certifier		29c. Licens			29d. Date signed (M		
	F>F0		Sannder Would	MID	$ \mathcal{D} ^2$	27188		11-21	1-09	
	21		30. Name and address of person who completed cause of death	(Item 23a) (Type 2 M/)	Print)	lace D	unda	(K My	21222	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 3 2009	Signature	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 20 Physician/ Harry W. Roberts 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Berlin Nursing & Rehabilitation Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Min 1 🛛 M 2 □ F Hours June 9, 1918 Marvand 215-07-4027 91 Director Usual Residence of Decedent errint. Page 1 and 2 should be filed within 72 hours after death with the Maryland Leg artment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amjoring or other traumatic event, the Medical Examiner must be notified at one. 10c. City, Town or Location 10d. Inside City Limits 10a. State **Funeral Director** Ocean Pines 1 Yes 2 X No Md. Worcester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? USA 21811 137 Nottingham Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Š 1 Never Married 2 X Married ts Harry , Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Drafting Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thiemeyer ပ Elizabeth Charles Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 Club View Lane Phoenix, Md. 21131 Linda Bowen/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 11-23-09 Timonium, Md. 4 Donation 5 Other (Specify) 21. Signature of Fundal Solice Lid 22. Nam RUCK TOWSON Funeral Home, Md. 1050 York Rd. Towson, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ungestive disease or condition Medical resulting in death) Due tur as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury Division of VItal Hecorus, F.C. DUA VOLVOLONO othe Hospital or Attending Physician: The law requires that the death certificate be executed nestansun the bunal-tran and that initiated events resulting in death) Last Due to for as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hours after death.

To the Funeral Director: After completed filled in by the fu

State Registrar 29a. Certifier

only one)

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

NOV 2 3 2009

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:30 PM Floyd Smith 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Northwest Hospital Center Randallstown Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 11/19/1928 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2□ F Months Days Hours 212-26-0798 81yrs. Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experient must be muffled at 10a. State 1 Yes 2 No Director Md. Baltimore Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ---- any injury or other traumatic events. 1720 Woodstock Rd. 21163 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 Yes, Give 1 Never Married Married 1 ☐Yes 2 No Specify: Specify White 2 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Job Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Jenkins Jessie E. Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret F. Smith(Wife) 1720 Woodstock Rd. Woodstock, Md. 21163. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodstock, Md. Granite Presbyterian 11/25/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Haight Funeral Home & Chapel P.A. P.O. Box 195 Sykesville,Md. 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UN Lancer disease or condition resulting in death) /Medical Due for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been si page 2 should to 1 🗆 Yes 2 🗌 No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?/ certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 Yes 2 **H**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 P Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2 To the and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ISKU apalise M.D

NIS. Rajapakse, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25 Main St., Suite 200

32. Registrar's Signature

29c. License number

DOUS7465

Reisterstown, MD. 21136

29d. Date signed (Month, Day, Year)

11/22/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:36 AM DKINNE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death UNIVERSITY OF MARYLAND MEDILAL CENTER BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NC 8. Date of Birth (Month, Day,)
Jan. 29, **Funeral** Days Year. Months 1 XM 2 F Director 246-96-3397 53 1956 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and to frem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No MD Temple Hills Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2224 Chadwick St. 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. þ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Black. Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Skinner Emma Brothers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Hazel Skinner - Wife</u> 2224 Chadwick St. Temple Hills, Md. 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or of once. 1 XBurial 2 Cremation 3 Removal from State Cedarwood Cemetery 11-21-2009 Hertford, NC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) WEEK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, being the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 2120 S. GREENE 31. Date filed (Month, Day, Year) State 23 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:35 PM Raymond Albert Sigwart, Jr. 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Under 1 Year | FUnder 24 Hrs. | 8. Date of Birth onths | Days | Hours | Min. | 06-03-1934 If Under 1 Security Number 9. Birthplace (State or Foreign Country)
Maryland Funeral 1**X** M 2□ F 216-30-6314 75 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28e-f shov irrer must be notified at Funeral Director 1 ☐ Yes 2 X No MD Worchester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 'nent of Health and Mental Hygiene. U.S.A. 21811 26 Duck Cove Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 2/215-0036 "natural", or ō 1 ☐ Yes 2 No 2 Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Albert Sigwart, Sr. Hazel McGee ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26 Duck Cove Circle, Berlin, MD 21811 Judith Sigwart/Wife t of Hea 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any In|ury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 11-23-2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MALIGNANT /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, and a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): s been signed by the ettending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed certificate has b rector, page 2 sh 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 10 No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence Other (Specify) HOSPICA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and Wile of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHUGHTY 130 K WAT 21301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of h	dealth and Mental Hygiene∠ U U

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7, 2009 Day **Physician** Month M39 Uvember Bobby Solesbee /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day Ye Baltimore N/A Jary land General spital 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1951 **Funeral** Months Days Hours Min 1 M 2 □ F 58 219-58-0918 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Kingsville 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12707 Lee Ben Rd. USA 21087 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐Yes 2X No \$ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Factory Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 Is marked o ပ (Unknown) Evelyn Sutton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sutton (Brother) 12707 Lee Ben Rd., Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: if ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 11/23/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION **Physician** leumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is a line flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 12 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland General Hospital Kenechukua Enekebe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Thomas Smith Medical 6 2009 :07a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4603 Homer Ave Baltimore Funeral 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 **X** M 2 □ F Months Days Hours Director 223-68-0607 64 09 NC Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits NA Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4603 Homer Ave U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 C Black, White, etc. Completed by 1 Never Married 2X Married 2 No 1 ☐ Yes 2 No Specify: If Yes, Give Black 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade na Maintenance Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eddie Lee Hinton Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Smith-Wife 4603 Homer Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place <u>Garrison Forest Vet</u> 11/23/09 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Baltimore, Ave, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final nset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ALCOHOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month the detached 9 Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy the Hospital or Attending Physician; The perform death? certificate 2 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) မ 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

900 CATON AVE

BALTIMORE MO

STAGNES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Den State Amend Item 26 per verb., g897, I	artment of Heal /23/09dhb .DV	th and M R ath	ental Hygi	ene g. No. 2 N N 9	371,27
			Negistrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Michel Robin Scott			Month October	26, 2009	4:00 PM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locat	ition of Death		4c. County of Death	1
			1316 Fenwick Lane #1318	Silver Sp			Montgome	
	Funeral		5. Social Security Number 6. Sex 1 N 2 F 7. Age (In yrs. last birthda) 7. Age (In yrs. last birthda) 72 rs.		nder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Aug 7, 1	Year) Cou	nplace (State or Foreign untry)
н	Director		226-56-3364 72 Yrs. Usual Residence of Decedent			Aug /, I	937 Fra	nce
	aryland show		10a. State 10b. County 10c. City, Town or L	ocation		-		10d. Inside City Limits
:	sa-fsl	cto	MD Montgomery Silver	Spring				1 ☐ Yes 2√☐ No
3	illed within 72 hours after death with the Maryland Hygiene, What "natural", or items 23a or 28a-f show ent, the medical Eveniment by multihed	al Director	10e. Street and Number 1316 Fenwick Lane #1318	10f. Zip Code 20910		10	g. Citizen of What Cou USA	untry?
	ems ?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	, or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	_	ecify:		Specify: wh	
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Jar				ling Address <i>(Street and N</i> 48 Sytherlan				
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Baltimore, Maryland 2	m U b.		1 🗆 Buria: 2 🗀 Cremation. 3 🗀 Hemoval from State	oosition (Name of ematory or other place)				
וב ו	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specify) in state 21. Signature (Fig. 1) Trace Licensee 1 Wirector S	22. Name and Address of F tate Anatomy	Facility and	655 W	Raltimore	Street
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C _c P	hysician	ı li	Immediate Cause (Final disease or condition	Tufantio	110		1	Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or a consequence of):	apriare 110				
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89	certificate be executed ading physician and ise as the burial-transit	Medi	IF FEMALE:			-		
Box	death certific	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	☐ Ectopic pregnancy			23d. Date of del Month	ivery Day Year
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٠.	ine law requires that the of ate has been signed by the page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in I	Part I.	23e. Did tob	acco use contribute to	the cause of death?
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>	nding Pnysician; th. : After this certifics funeral director, p	10E	examiner? 1 Yes 2 No Hospital: 1 Inpatient ZER/Porpat		☐ Nursing Ho	me 5 Reside	nce 6 ☐ Other (Spe	cify)
ם י	Ing P	Ö	27. Manner of Death 128a. Date of Injury 28b. Time (Month, Day, Year) 28b. Time (Injury) 28b. Time	Work?	_	28d. Describe ho	w injury occurred	
Sio	ttend leath ttor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes		28f Location (St	reet and Number or Ru	iral Route Number
Division of	after after Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, lactory, office		City or Town		arai Floate Nambol,
	e Hospita or Attending Pnysician: 124 hours after death. e Funeral Director: After this certifica		29a. Certifier Certifying Physician: To the best of my knowledge, de	ath occurred at the time, da	late and place,	and due to the c	ause(s) and manner a	s stated.
:	Io the Hosp within 24 hor To the Fune completely fi	edical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.					
ı	With Common South	Σ	29b. Signature and the of certifier	29c. License num	mber	2	9d. Date signed (Mont.	h, Day, Year)
			" Everellowed spes, M)	1 000	シナミ	304	11/6/0	9
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		Mn a	0895	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Kensing H		1110 0	087.3	
	Registr		NOV 2 3 2009 Senera B. Ja	, Kensing h				

1¥ Yes 2 □ No

Approximate Interval Between Onset and Death

Day

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Speake 20, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAIT, MORE KCHAB RHEALTK ESSEX CIVERVICE 5. Social Security Number If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-40-2249 1 □ M 2 🔀 F Months Days Hours 66 MATYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercites rount to notified a once. Britimore Funeral Director MATILAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. leasant 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Yes. Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) DRY CLEANERS Elementary/Secondary (0-12) College (1-4or 5+) CASHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARTIN ပ 19b. Mailing Address (Street apd Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) leas not daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 9 Odenton, MARYLAND 5. ZANNINO ZICENSEL MOST GEHATORY 11-23 -09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Charles 21. Signature of Juneral Service Licensee 5. CONKLING Street 23a. Part 1. Enter the sees shock, or heart situal. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on ear line Immediate Cause (F Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) P.0. I∐Yes 2 2No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 ъ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an performed After this certificate 2 🗓 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 0 - 3 8 7 5 4 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A HUHA W HSREM FOR. B Print) BASTERN BLVD, MD-21221 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month O 1 Day MAZIF **Physician** 20 2009 lay 777 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Howard County General Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Vear **Funeral** Min. Hours Months Days 1 □ M 2 🛣 F Maryland May 6, 93 214-24-0562 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Heath and Mental Hygiene.

Heath and Mental Hygiene.

Province 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, if a Natural is the invelled a law the traumatic event, if a Natural is a Na 1 ☐ Yes 2XXXNo Director Arbutus Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 949 Elm Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 NO 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify If Yes, Give Year or Dates: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cosmetology 12 Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie B. Swann George Τ. Burch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arbutus, Maryland 21227 949 Elm Road permit. Pages 1 and :
Department of Health
Important: If Item 27
any injury or other tn
once. Melvin J. Sanders, Jr./Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Crepagt 3 Removal_from State Baltimore, Maryland ∞rraine Park Cemetery 11/25/09 4 □ Donation 5 🗷 Q 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease or complications that causeum heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 1740. W-1 /Medical Due to (or as a conservence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death □Yes 2√No Division of Vital Records, P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 **K** No 2 No certificate 1 □ Yes Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **K** No 1 Inpatient 2. ER/Outpatient 3 □ DOA 1 ☐ Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury 1-X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

24 hours a

State Registrar 29b. Signature and title of certifier

Bealla

/32. Registrar's Signature 31. Date filed (Month, Day, Year) 23 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZOO9 8:20 AM Dorothy Tubman Margaret November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospita Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year)

94 03 29 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2💢 F Director 213-26-4258 Yrs 80 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 No MD NA Baltimore 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 3019 Ferndale Ave 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify 3 Divorced Specify: Completed Black 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Weber Nursing Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse 12th grade 2yrs is marked other Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Burns Lillian Mackel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 3019 Ferndale Ave, Baltimore, Md 21207 Antoinette Tubman-Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a Department of h 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 11/25/09 Arbutus, Md 21. Signifure of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, trome baltimore, Md 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner tract Sequentially list conditions Examiner cause (Disease or iinjury that initiated events Due to for an a continuouence off: physician and s the burial-transit resicovaa resulting in death) Last Due to (or as a consequence of): Physician/Medical with metastases cancer 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation with rapid 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? response 24a. Was an performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 DeInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RES-000 November 18, 2009 Marina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital , 2401 W. Belvedere Ave. Baltimore, Maryland Pratt Marina 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State

Registrar

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Khown as

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #18 & 196, per FH 2897 11/23/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 7 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2009 7:39 PM November Sherry Lynn Wade Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Sykesville 614 Kalorama Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 27, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours 1 □ M 2 😾 F 55 290-56-9397 Yrs 1954 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Svkesville MD Carroll 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21784 US 614 Kalorama Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Banking 12 Branch Mgr Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Genevieve Diltaz Frank Miele 19a, Informant's Name/Relationship (Type, Print) vkesville MD 21784 614 Kalorama Road. S Jennifer Spampinato (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Lake View Memorial 11-25-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Haight Funeral Home ▶ Parge Harget Herbert PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GLIOBIA STOMA

Due to (or as a consequence of): MULTIFORME Pnysician/ disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown isigned by the at Id be detached fo 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural iniury work' 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af death. Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number R097025 29d. Date signed (Month, Day, Year) 29b. Signature and title of MOCRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar FERRIGNO

1550 ORG 32. Registrar's Signature

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ORLEANS STICRB2, IM-16, BALTO, MD

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 2009 **Physician** 7:00 PM ELIZABETH KARIN WHITE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sep. 26, 1983 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 □ F 26 Maryland Director 213-06-9956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examin sermest be rediffed at once. 1 ☐ Yes 2 X No Director Virginia Fairfax Vienna 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9507 Chestnut Farm Drive 22182 USAFuneral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: <u>}</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Our Lady of Good Elementary/Secondary (0-12) College (1-4or 5+) Counsel Catholic School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Thomas White, Sr. Kathryn Anne Schnittker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9507 Chestnut Farm Dr. Vienna, Va.22182 Arthur Thomas White,Sr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Money & King Crem. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chantilly, Virginia 4 Donation 5 ☐ Other (Specify) Schwices and Address of Facility Money & King. Funeral Home, 21. Signature of Funeral Service Licensee Gary R. Downer 171 W. Maple Ave., Vienna, Va. 22180 ANUI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 years 5 months **Physician** Primary Mediastinal disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner myt versus Host Disease of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟ Yes 2 🗆 **أي**ا 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours af er death.

To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1939 - ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 SARAH SINCLAIR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 23 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 3:30 P M 2009 James G. Ward November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 971 Stormont Circle
5. Social Security Number 6. Sex Baltimore r1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**⊠**M 2□ F Yrs. New York Director 9/21/50 198-42-6069 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examination at the motified at 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 971 Stormont Circle 21227 <u>USA</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Mercy Medical Center marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fill h and Mental H ris marked oth Mabel Blankenship Samuel Ward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an Baltimore, Maryland 21227 Mrs. Erica L. Ward / Wife 971 Stormont Circle Department of Health Important: If item 27 any Injury or other tr 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 11/19/09 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lice 3620 Wilkens Ave. Baltimore, maryland 21229 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CAUC march ! 1.4 C /Medical to (or as a c equence of): Examiner 2008 JA400) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner be executed burial-trar Due to (or as a consequence of): physician the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f Ö 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed certificate 1 ☐ Yes 2 Z No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) (1-5 Pic 1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. 124 hours after death.

Re Funeral Director: A pletely filled in by the fi 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated.

Under the date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 360 40 W Delu Edece ave Bult. M.721215 30. Name and addiess of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

09-08875
Thomas Wolf

homas Wolf	Re	State of Maryland / Department of Health and Mental For State State of Maryland / Department of Health and Mental Certificate of Death State of Maryland / Department of Health and Mental Certificate of Death		eg. No. 2	009 37431
Physician/	1.	Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Yea r 15, 2009	3. Time of Death 1530 hrs
nedical Examine	46	homas Clayton Wolf a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. County	of Death
		a. Facility Name (if not institution, give street and number) Sacred Heart Hospital the WMHS 4b. City, Town, or Location of De Cumberland		Allegany	
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Min.		9. Birthplace (State or Foreign
Director	2	16-25-1792 1XXM 2 F 20 Yrs.	Aug.	22, 1989	Country) Maryland
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th the Maryland 23a or 28a-f show notified at once.	11	aryland Montgomery Woodbine De. Street and Number 10f. Zip Code		10g. Citizen of W United	hat Country?
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be file be file mral H refect	S	CCVCII OLGYCOII NOLL	ret Mott	Meighan	wn State Zin Code)
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 rent of Health and Mental Hygiene. ant: If item 27 is marked other than " rother traumatic event, the Medical To Be Complet	- 1	1			1
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Media.		4 Donation 5 Other Specify: McReTioTee Cemetery 21. Signature of Funeya Service Licensee			
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Divalors af	Certification:	4 Homicide determined (Specify) campus	131 H	ill St.	Cumberland, MD
(3/6 = 5)		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the our curred at the time, d	cause(s) and man late and place, an	ner as stated. Ind due to the cause(s)
To th within To th comp	Medical	2 Medical Examiner. On the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner that a way of the control of the basis of examiner than a way of the control of the basis of examiner than a way of the control o			signed (Month, Day, Year)
		O.C.M.E.		Novemb	er 17, 2009
	-	30. Name and address of person who completed cause of death (Item 23a)			
if		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Balt	timore, MD 21	201	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
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			1. Decedent's Name (First, Middle, Last)			inoato or z		2. Date of Deatl		3. Time of Death
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-	,		7515 Cameron Ridge R 5. Social Security Number 6. Sex	oad 7. Age (In yrs. las	t hirthdoul	Hughesv If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Charl	es Birthplace (State or Foreign
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	or 28 e not		10e. Street and Number		8	10f. Zip Code		1	0g. Citizen of What	Country?
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	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Arr	as Decedent Ever in U.S. med Forces?		as Decedent of Hi Yes, specify Cuba			14. Race - Ar Black, Wi	nerican Indian, nite, etc.
Baltimore, Maryland 21215-0036	rs after Iral", o Exam	Completed by	a Division of the lift Y	$\overline{\overline{X}}$ Yes 2 \square No res, Give ar or Dates. ${}^{f t}$ 5 1 $-$	71 1	☐ Yes 2 🔀 No	Specify:		Specify: Wh	nite
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lan	should and N is me		19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
≥,	nd 2 is lealth m 27 ner tr		Mei Y. Wieck/ Wife				Ridge R		esville, N	
lore	ye 1a tof H if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 【X】 Cremation 3 ☐ Remov	ral from State	metery, crem	sition (Name of natory or other plac			20c. Location - City	
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Ba	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	~	3	3035 Old	Washing	ton Road		MD 20601
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	ns that caused the death e on each line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition	metastahi		ate concer				Onset and Death 57 marks
-	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
		Jer		Due to (or as a consequ	ence of):					
	nted d ansit	Examiner	Cause (Disease or iinjury that initiated events c							
	exectian an	Ë	resulting in death) Last	Due to (or as a consequ	ence of):					
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Box 687	hat the death certifics led by the attending p detached for use as i	Physician/Me	in the past 12 months?	Live Birth 2 Fetal Pregnant at time of d	ideath 3 🗀	Ectopic pregnand Other (specify)	су		Month	Day Year
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, P.O.	gn ge		Part II. Other significant conditions contribut	ing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
rds	require been si should I	etec						24a, Was a	n 24b. Were	autopsy findings available
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Vita	Physici this cer al direc	일	examiner? 1 Yes 2 No Hospita	al: 1 Inpatient 2	ER/Outpatier	nt 3 🗆 DOA	er: 4 🗌 Nursing l	lome 5 Reside	ence 6 Other (Sp	pecify)
of	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending	a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur work	?	28d. Describe ho	w injury occurred	
ion	ttendi death. tor: A the fu	Certificate:	2 Accident Investigation	Diago of Injury. At ho	ma form atr		Yes 2 No	20f Lagation (Ct	tract and Number or	Rural Route Number,
Division of Vital Records,	al or At after of Direct		4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify)		eet, ractory, onice		City or Town		nurai noute Number,
ں ارن	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a, Certifier 1 Certifying Physician: (Check 2 Medical Examiner: On	the basis of examination	and/or invest	tigation, in my opinio	on, death occurred	at the time, date an	id place, and due to t	ne cause(s) and manner stated.
11	o the	ž	only one) 3 Certifying Nurse Prac 29b. Signature and title of certifier	tioner: To the best of my	knowledge, o	death occurred at the 29c. License			cause(s) and manner 29d. Date signed (Mo	
	⊬ ≯ F ŏ		· curs				56024		Nov Z	2009
			30. Name and address of person who complete	ed cause of death (Item	23a) (Type, F	Print) Sule 1	10 Pri	ne Freder	ide HI)	20678
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Sarked				
	Registr	ar	NOV 2 3 Z005	Museum	1. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 Ames 1455el 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death A MediCAL BALTIMORE SALT: MORE V enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 2 - 20 - 1953 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours X M 2 □ F MD 55 Yrs 215-64-7837 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Xes 2 ☐ No Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1973 Guy Way 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □**X**lo If Yes, Give Year or Dates: Vietnam Specify. Specify: White 3 ☐ Widowed 4 A Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Eddins Ray P. White, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1973 Guy Way, Dundalk, MD 21222 Ray White - Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bayview Crematory 11-21-09 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee Spring Road, 2134 Willow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BACTERIAL disease or condition resulting in death) Due to (or as a consequence of): teomyel. Sequentially list conditions, if any leading to firme-clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760. attending p Ö σ. Division of Vital Records, has certificate I After this

Physician

/Medical

Examiner

Director

Funeral

\$

Completed

MD

Funeral

Director

show

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it a Medical Examinar marst barnofflied at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic events.

Physician

/Medical

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

signed by the a page 2 Hospital or Attending Physician: funeral director, 4 hours after death.

*uneral Director: Af
ely filled in by the fur within 24 hours a

To the Funeral D completely the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SORDAN State

3 ☐ Suicide

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be

determined

O NORTH GREENEST BALTIMORE MD 21201 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Julia M. Warhurst 18 2009 7:30A /Medical Nov 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs. Director 213-12-2283 90 9-22-1919 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be netflied at 1 TeYes 2 □ No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ∐Yes 2≱∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No Specify: White ⋧ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Magnone. Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary LaW

18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Steve Peterka Theresa Mehlmever 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Clark-Daughter 605 Elmwood Road, Baltimore, MD 21206 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 11-18-09 Baltimore, MD 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 251 **Physician** weeks /Medical Due to (or as a consequence **Examiner** 40,15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2.X No 1 □ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

Vital Records, Hospital or Attending Physician: The law requires i 24 hours after death. Funeral Director: After this certificate has been sign Division of WARHURST

P.O.

that the death certificate be executed

with the Maryland

death v

72 hours after

Maryland 21215-0036

VOVEMBER Baltimore,

within 2 To the I

29b. Signature and title of certifier

31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001

State

ERNESTINE WRIGHT, M.D32. Reastrar's Signature 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM MD

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Virginia L. Watts November 2009 3:00 AM/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice of the Chesapeake Linthicum Glen Burnie 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Mar 14, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 🛱 F Months Days Hours 220-18-1953 84 Mar Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f show Director 1 ☐ Yes 2√☐ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 714 Cotter Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedo... _ Armed Forces? 1 □Yes 2∑No 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: White Specify \$ 3 Widowed 4 □ Divorced "natural" Completed d other than "natu event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ... within 127 is marked other than "r. r traumatic even* Elementary/Secondary (0-12) College (1-4or 5+) 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Girlden Leister Anna Freyer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Watts/daughter 8154 Bell Tower Crossing Pasadena, MD item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any injury or c 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade ²² State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201

23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Drova disease or condition resulting in death) /Medical Due to_(or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed \circ Jasculu 1500 anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 2 X No 2 No 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 0 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Year

			For State	State of M	arylan	-	artment of I tificate of I			lental Hy		2009	37439
			Registrar 1. Decedent's Name (First, Middle, I	Last)		Cer	uncate or i	Jean		2. Date of De	_	200	3. Time of Death
	Physicia		Richard	,	thon	У	Ya	tes		Month	Day	2009	3:15p. M
	Medic Examin		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, o	r Location	n of Death			County of Dea	-
	Examin	J.	2626 West Laf	ayette Av	е		Balt	imo	re				
	Funeral		Social Security Number 6	. Sex 7. Ag	e (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bi		9. Bir	rthplace (State or Foreign
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	items er m	F	11. Marital Status	12. Was Decedent B Armed Forces?		5. 13. V	Vas Decedent of F Yes, specify Cuba	lispanic (Origin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, Whit	
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yla	should be file and Mental F is marked o raumatic eve	မ	John A. Yate	s				Ma	ry E	. Bur	cell		
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пōг	age 1 int of l t: If it		1 😾 Burial 2 □ Cremation 3			emetery, cren	natory or other pla					odlawr	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot	1	4 ☐ Donation 5 ☐ Other (Sp 21. Si				llawn . Name and Addre		11/2	1/09	WOC	Julawi	r, na
Ba	permit Depar Impor any in	l d	Verme.	7. Stomp	ma(Name and Address F/ BOO Wab	H We	est Ave.	Balt	imor	e, Md	21215
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89	certil andine use a	Jug N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnan	icv			2	3d. Date of d	elivery
Box 68760	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a			Other (specify)					Month	Day Year
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σ,	v requires that s been signed k should be det	l by	Part II. Other significant condition		4								Probably 4 Unknown
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Ö	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director.				77.500	la la sala					auga(a) and	d manner as a	tatod
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of a Nurse Practioner: To the	xamination	and/or invest	tigation, in my opin	ion, death	occurred a	t the time, date	and place,	and due to the	e cause(s) and manner stated.
V	Fo the within 2 comple	2	only one) 3 L Certifying 1 29b. Signature and title of certifier	Vurse Fractioner. 10 Je	DØST OF HIS	r Knowledge, c	29c, Licens	se numbe	r		29d. Date	signed (Mon	ith, Day, Year)
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	•		30. Name and address of person w		leath (Item	23a) (Type, F	Print) CAL	20 0	MET	H PT.	eb '	ARRT	1003 HOLARD HD 21052
			KISHORE	-0 1	MA	7	100) O 1			- ,		MD 21052
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Registr	ar's Signat	ture .	Day Co						

ayson Ikenna A	1		artment of rtificate of			Reg. No. 20	09 3744
Physicia	ın/	Decedent's Name (First, Middle,Last)			2. Date of D	Day Year ber 9, 2009	3. Time of Death 2014 hrs
Medical Exami		JASON IKENNA AMAKOR 4a. Facility Name (if not institution, give street and number)	· 1.	4b. City, Town, or Location		4c. County of De	
		Prince George's Hospital Center		Cheverly		Prince Geo	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1219-85-3523 1 X M 2 F	last birthday) Yrs	Months Days Hou	ırs Min.	6-2009	Birthplace (State or Foreign Country) DC
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Locat	ion			10d. Inside City Limits
	١	Maryland Prince George's Su	uitland				1 Yes 2 No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Realth and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number 4804 Moss Place		10f. Zip Code 20746		109. Citizen of What C	Country?
r death with th	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No		s Decedent of Hispanic C es, specify Cuban, Mexic		White, et	
after d al", or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X No speci		Specify: B1	
hours natur Exam	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Deceder during m	nt's Usual Occupation (Givents of working life, DO NO	ve kind of work done OT use retired)	16b. Kind of Busine	ess/Industry
136 thin 72 re. than '	Completed	O College (1-4 of 51)	Inf	ant		Infant	
5-00 lled wii Hygier I other		17. Father's Name (First, Middle, Last) Michael Amakor			ner's Name (First, Midd nwe Egbule		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	m	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and N	_		State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		Michael Amakor/father		Moss Place,			
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	. Place of Dispos crematory or of	sition (Name of cemetery, her place)	Date	20c. Location - Cit	y or Town, State
Pages nent of ant: I		4 Donation 5 Other Specify:		Memorial Cem		09 Suitland	, Maryland
Balti permit. Departm Imports		21. Signature of Funeral Service Licensee Many Hedaman 1901374		Name and Address of Fac lar Hill FH		ve Suitla	nd, MD 20746
Physician		23a. Part I. Enter the disease, or complications that caused the deat					Approximate Interval Between Onset and
/Medical	8 - JD	failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexp1					Death
xaminer		or condition resulting in death) Due to (or as a consequence	of):				
	ě	Sequentially list conditions, if any, leading to immediate b	of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated overtice resulting in (east)). Last	of):				
executed an and al - transit	Ĕ	events resulting in death) Last Due to (or as a consequence d.					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pre	egnancy 2 F		opic pregnancy	23d. Date of de Month	livery Day Year
O. B at the d I by the tached	, Ph	Part II. Other significant conditions contributing to death but not	t resulting in the	underlying cause given in			te to the cause of death?
s, P.	d by						Probably 4 V Unknown
Records, P.C. The law requires that cate has been signed b	Completed						re autopsy findings available or to completion of cause of ath?
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of V ig Phy fiter thi neral d	: To	1 Ves 2 No Impatent 2.3 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Injury at V		cribe how injury occurred	
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Division of Vital F Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	ical Ce	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination	edge, death occi	urred at the time, date and	d place, and due to the	cause(s) and manner as	s stated. e to the cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier		29c. License num			(Month, Day, Year)
		MILLANI		O.C.M.E.		November 1	0, 2009
		30. Name and address of person who completed cause of death (Ite		4 Dama Otal 1 D 11	imana NAD 04004	1,	,
		Russell Alexander MD. Assistant Medical Exa		1 Penn Street, Balt	imore, MD 21201		
S Regis	tate trar		bare	W			
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OCME 2006							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 November 7:30 a Pami Leah Ard /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cecil Port Deposit 180 Waibel Road 8. Date of Birth (Month, Day, Feb. 19, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex ^{Year)} 1963 **Funeral** Months Days Hours 1 □ M 2 🔽 F 218-82-5831 Feb. 46 Director South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2 💢 🐪 Vo Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 U.S.A. 180 Waibel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc 1 ∏Yes 2 ☑ If Yes, Give Year or Dates; 1 Never Married 2 ☐ Married 2 X No 1 ☐Yes 2 ☑ No Specify Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Union Hospital of Cecil County Baltimore, Maryland 2121 Two Years Elementary/Secondary (0-12) Pharmacist Assistant Elkton, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William R. Ard Doris J. May ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 78, Perryville, Maryland William R. Ard (father) 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/10/09 R.A.Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 21. Sign sure of Funeral Service Licens e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1stemic LUDE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) ned by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2√☐√No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 □ Yes 2 🗓 No 1 ☐ Yes 2 🙀 No : After this certification of the thick of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🂢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific November 9, 2009

DHMH 17 Rev 1/2001

State

Registrar

Box 68760,

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Stephen Naylor, D.O., 535 Rowlandsville Road, Conowingo, Maryland

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1 0 2009

State of Maryland / Department of Health and Mental Hygiene, 37442 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month A M 2009 0730 Helen E. Algard November /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 2391 Oldfield Point Road E1kton Ceci1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Director 91 221-10-0228 DEC 14, 1917 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 28a-f show event, the Medical Exerciner must be notified at Director 1 ☐ Yes 2 📉 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2391 Oldfield Point Road United States filed within 72 hours after death Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married o, Maryland 21215-0036 If Yes, Give Year or Dates 1 □ Yes 2 No 2 Specify Specify: 'natural", 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Bus Driver <u>Transportation</u> 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental ၉ (Unknown) Nesci (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other troops. Christopher Algard/Son 918 Branch Road, Newark, DE 19711 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 12, 2009 Wilmington, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final A/herosclero **Physician** Unknoon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of), Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical 29a, Certifler 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11.10.2009. 00023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 ECETON MD 21921. SACHDEN MD 126 A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For Amend Item 12 per fh, g85	97,11/23 Cel	/09dhb rtificate of D	eath	Reg	2009	37443
	Physicia	an	1. Decedent's Name (First, Middle, Last) Lawrence W. Abe				Month Nov. 14	Day 2009	8:05 P M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death	NOV. I	4c. County of Deat	
	Examin	er	Frostburg Assisted Livi	na	Frostb			Allegan	
**	Funeral			rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	hplace (State or Foreign
	Director		214-12-3025 X□M 2□F 87	Yrs.	Months Days	Hours Min.	Apr. 25	б [™] 1922 й	aryland
	D.		Usual Residence of Decedent						10d. Inside City Limits
	show	_		City, Town or Lo Prostbu					1 1 Yes 2 No
	8a-f	Director		LOBLDU					
	ith th	Dir	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	ath w	Funeral	100 Village Parkway		215		naih. Van ar Na	U.S.A.	rican Indian
	items	ığ	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, White	
20	hours atter death with the Maryland tural", or Items 23a or 28a-f show at Evanities must be rediffed at	by F	1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW	II	1 □Yes 2 □ No	Specify:		Specify: W	hite
5	be filed within 72 hours after death with the Marylan tall Hyllene. Ital Hyllene. Italian "Research and the second of the Hyllene and the second of the Hyllene and the resulted at event, the Marked Eventher must be rediffed at	per	15. Decedent's Education	16a. Dece	dent's Usual Occupat	tion	10	b. Kind of Business	Industry
1215-0036	e. In "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done du DO NOT use retired)	_	ng		
7	d with giene	М Ш	11	Boil	ermaker	Helper		CSX	
2	should be filed v nd Mental Hygie marked other t umatic event, Ib	Be (17. Father's Name (First, Middle, Last)				(First, Middle, Ma		
<u>a</u>		၉	Clayton Abe			Bernice	e (Bucl	cley)	
Maryiang z	0.00 5		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street ar				
	5 ± 0 =	1 13	Larry F. Abe Son		Talcott			. 5 /	21532
9	of of	ľ	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other place,			Oc. Location - City or	
altimore,	. Pag tmen tant: jury			Zion Me				Cumberla	
Ra	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ucensee Word A. Lachuck		2. Name and Address 302 Nati	110		neral Se Vale, MD	rvice PA 21502
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
S.	Physician	S 1	Immediate Cause (Final disease or condition	2 min	scordia	huja	vilian		Onset and Death
	/Medical		resulting in death) Due to (or as a cons	sequence of:		1000	0.00	-0	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	.51				
	and and I-tran	хап	that initiated events resulting in death) Last Due to (or as a constitution)	sequence of):					
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68760,	ate Ph	edical	d						
. Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pre 1 □ □ Live birth 2 □ F 4 □ Pregnant at time	Fetal death 3 [☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	llivery Day Year
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Division of Vital Records,	The law retue has be rage 2 she	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of s 2 □ No
<u> </u>	ian: rtifica ctor, p	Be C	25. Was case referred to medical			26. Place of Deat	h (Check only one		
<u>-</u>	nysic nis ce direc		examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA Othe	r: 4 🗆 Nursing Ho	ome 5 Resider	nce 6 other (Sp	ecify) LIVING
0	ng Pl	Ë	27. Manner of Death 12 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	Work?	at ?	28d. Describe how	w injury occurred	
010	rendi eath. or: A the fu	cati	2 Accident investigation			es 2□No			
<u> </u>	or Att fter d Sirect in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, st pecify)	reet, factory, office		City or Town,	eet and Number or F State)	lural Houte Number,
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	Hos 24 hc Fun Fun	edical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 2 Medical Examiner: On the basis of examone; and manner stated.	mination and/or i	nvestigation, in my op	pinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
	o the	Mec	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Mor	th, Day, Year)
	⊢ ≶ ⊢ ō		Hellu		026	907	~	SOVEMBI	ER 16,2009
,			30. Name and address of person who completed cause of death ((Item 23a) (Type.		1	- /	, , , ,	
			Hariit S Sidhu. MD 925	Bisho	p Walsh 1	RD Clim	berland	, MD 215	0.2
	Sta	ite	Harjit S Sidhu, MD 925 31. Date filed (Month, Day, Year) 32. Registrar's S	Bisho gnature	p Walsh 1	RD Cum	berland	, MD 215	502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 23, 2009 8:50 P M Theodore Babeck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 126 Gathering Court Sudlersville Queen Anne's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/22/1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 XM 2□ F Days Hours Min. Director 89 159-05-6565 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madeal Examinar must be notified at 1 ☐ Yes 2 No Director MD Oueen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21668 USA 126 Gathering Court 12. Was Decedent Ever in U.S. Armed Forces? 1 23 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1∐Yes 2ŽNo If Yes, Give Year or Dates: WWII Specify 3 Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Procurement Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked ott any linjury or other traumatic even ones. Wonifat Babeck Fanny (unknown) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Cook/Daughter 126 Gathering Court Sudlersville, MD 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10/26/09 Stevensville, MD 21. Signature of Funeral Service License 22. Name and Address of Eaclity Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do , t enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: nse i 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Mann Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

be executed Box 68760, P.0. Division of Vital Records,

attending physician signed by the a has certificate Hospital or Attending Physician: After this within 24 hours after ucc...
To the Funeral Director: After

and 2 should be filed within 72 hours after death vealth and Mental Hygiene.

Baltimore, Maryland 21215-0036

5 Pending investigation 1 Tyes 2 □ No 2 Naccident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier	1 Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Signature and title of certifie

D36057

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharahar atric 120

31. Date filed (Month, Day, Year)

32. Registrat's Signature

peer Rd Bldg B Chestertown MD 21620

5+1

Medical

State Registrar

			For State Registrar	State of Marylar		artment of H rtificate of L		l Mental Hy		°2009	37445
			Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
	Physici /Medi		Roseann Marie Bridg	man				Novem	bor		09 4:5 0 PM
	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Dea			c. County of Deat	
			Berlin Nursing Home			Berlin				orcester	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. M 2図F 71		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year	9. Birt	thplace (State or Foreign
	Director		1/0-30-/229	VI ZIAI / I	Yrs.			07/24/	1938	B PA	
	fand ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary i-f sh	to	MD Worcester	Į.	Berlin						1 □Yes 2KINo
	r 283	Director	10e. Street and Number		CLILII	10f. Zip Code			10g. C	itizen of What Co	l puntry?
	death with the Maryland ms 23a or 28a-f show	a D	8 Pinehurst Rd.			21811			USA	A	
•	ems er m	Funeral	11. Marital Status	. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	(Specify Yes or No	0-	14. Race - Ame Black, White	
36 M	or it	by Fu	1 Never Married 2 Married	1 ∐Yes 2X∑No lfYes, Give		1 ∐Yes 2√E No	Specify:	The tillian, etc.,		Specify: wh	,
OSEANN M. 21215-0036	hours tural"	g p	3 Widowed 4 Divorced	Year or Dates:	10- D				101.1		
ROSEANN 3 21215-00	in 72 "na"r	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of w	orking	160. r	Kind of Business/	industry
212	with giene r than	mo l	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	· ·			Ноп	ne	
NG NG	othe Jent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	1		
lar.	uld be Ments rked ric ev	To E	John Mulderig				Margare	t Mulder	ig		
(A)	and l	ľ	19a. Informant's Name/Relationship (Type	Print)	19b. Mailir	ng Address (Street a	and Number or I	Rural Route Numb	er, City	or Town, State, 2	Zip Code)
Ð, €	and and and and and and and and and and		Alfred Bridgman,Jr	-		ehurst Rd	. Berli	n, MD 21			
O S	ges 1 t of H if iten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Real		Place of Dispo cemetery, crer	sition (Name of natory or other place	e)	Date	20c. L	ocation - City or	Town, State
BRIDGEMAN, R Baltimore, Maryland	t. Par tmen tant;		4 ☐ Donation 5 ☐ Other (Specify)		munity	Church C	em. 11/	07/2009	Ber	clin, MD	_
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Macical Evaminer must be redffed at once.		21. Signat e o Funeral Service Lice see	1.00		2. Name and Addres					Home
			23a. Part 1 Enter the disease or complica	tions that caused the day		08 Willia				811	Approximate
		8 19	23a. Part 1 Enter the disease or complica shock, or heart failure. List only one Immedia. Cause (Final	TO MADE TO THE PARTY OF THE PAR					arrest,	-	Approximate Interval Between Onset and Death
	Physician /Medical		disease r condition resulting in death)	metasta		nain	cance				
	Examiner			Due to (or as a consec	querice oi).						
		ner	Sequentially list conditions, if any, reading to immediate	Due to (or as a consec	paches off):						
	ecuter nd transi	Examiner	ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
90,	oe exectan a		resulting in death) Last	Due to (or as a consec	juence of):						
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		/Me	IF FEMALE:	:. If yes, outcome of pregn	ancy						
Вох	leath certif attending for use as	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	aldeath 3 🛭	Ectopic pregnancy Other (specify)				23d. Date of del Month	livery Day Year
O.	uires that the de signed by the a d be detached t	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
о. С.	s that ined t	by PI	Part II. Other significant conditions contr	buting to death but not res	sulting in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rg	quires							1 🗆	Yes 2	2 □ No 3 □ Pi	robably 4 Unknown
တ္ထ	e law requi has been s e 2 should	plet						24a. Was		24b. Were au	utopsy findings available
of Vital Records,	The I	Completed						- auto perfo	ormed?	death?	completion of cause of 2 □ No
'ita	slcian: The certificate h rector, page	BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check only		0 1 1 1 1 6 3	2 🗆 110
_	Physic this ce al dire	2	1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	ot 3 DOA Othe	r: 4 🖪 Nursing	Home 5 ☐ Res	idence	6 ☐ Other (Spe	ecity)
ū	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work		28d. Describe	how inju	iry occurred	_
Si.	tend leath. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2□No				,
Division	al or Attendii s after death. I Director; A d in by the fu	ertification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stro fy)	eet, factory, office		28f. Location ((Street a wn, Stat	nd Number or Ru e)	ural Route Number,
_	spital ours neral filled	O	29a. Certifier 1 Certifying Physic	ian: To the best of my kno	owledge, death	occurred at the tim	ne, date and pla	ce, and due to the	e cause(s) and manner a	s stated
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use at	Medical	(Check only 2 Medical Examine	r: On the basis of examination and manner stated.	ation and/or in	vestigation, in my or	pinion, death oc	curred at the time	, date ar	nd place, and due	to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	- 0	0	29c. License	number		29d. Da	ate signed (Mont	h, Day, Ýear)
			Menne Jan	Jaga CKM	ρ	K13	5131	,	Nov	12000	}
			30. Name and address of person who com	pleted cause of death (Iter		Print)	R. 1		-	•	
	打3		Tehnie Davage		lealth	wayer	, 42e/11	W 1119	4	1011	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa		h	1	in ma			
	riogiotii	4	1400.1 2005	► NOV 0	0 2009	Geneva	B. 19	an re			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) South Carelina 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Min. Hours 1 □ M 2 XF 32-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show injury or other traumatic event, the Medical Evar, that a ust be notified at 1 es 2 No Director WINE 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumation. tom in Strative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Typę. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) langerPRatt Daugher 141 206 B Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1₽Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vergreen Vlemonz! [seman Funeral W020746 Tace Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the use on each line. Immediate Cause (Final **Physician** John J CHO WAS disease or condition resulting in death) /Medical equence of): Examiner Sequentially list conditions, if the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes No certificate Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 1 Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death. le Funeral Director: A bletely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical соmpletely (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

NOV 1 0 2009 Registrar

31. Date filed (Month, Day,

who completed cause of death (Item 23a) (Type, Print)

			1 - State State Registrar	-	artment of Health and rtificate of Death	Mental Hygie	711119	37447
F			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici -/Medic		O'Cconel Boston				2009	5:35p м
	Examin		4a. Facility Name (If not institution, give street and no	mber)	4b. City, Town, or Location of De		4c. County of Deatl	
			1007 John Street		Salisbury If Under 1 Year If Under 24 H		Vicomico	
П	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 63 Yrs.	Months Days Hours Mi	in. (Month, Day, Ye	(ar) Co	nplace (State or Foreign untry)
			213-44-0886 Substitution of Decedent	0.3		8 13 1	946 MD	
	yland		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	a-f e	ctor	MD Wicomico	Salisbur	:v			1 XXYes 2 ☐ No
	िम प्रम् 0 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-f ehow the Medical Exampler must be motified at		669 Fitzwater Street		21801	υ.	S.A.	
	teme ren	Funeral	Amed F	orces?	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by F	1 Never Married 2 Married 1 Yes If Yes, G 3 Widowed 4 Yoivorced Year or I	2 XNo	1 ☐ Yes 2X No Specify:		Specify: Black	
8	hour	ed t	15. Decedent's Education		dent's Usual Occupation	166	Black b. Kind of Business/	
5	in 72	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of w DO NOT use retired)	vorking	. Killa of Dasillessi	moustry
212	r the	mo	Elementary/Secondary (0-12) College (1-40(5+)	N/A	Di	sabled	
פַ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's N	lame (First, Middle, Maid	den Sumame)	
/lai	uid b Ventz rrked rrked	To	Robert L. Boston, Sr	•	Evelyn	Brinkley		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow empt injury or other traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or	-		(ip Code)
≥.	and salth m 27		Thomas Boston/Brothe	er 805	Price Road, S	alisbury,	MD 2180	1
Baltimore,	ges 1 if ite		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □Removal from	State 20b. Place of Dispo	sition (Name of natory or other place)	Date 20c	. Location - City or	Town, State
Ë	ment tant: jury		4 Donation 5 Other (Specify)	, Direct C	remation, "'-	9-2009 Do		
3all	ermit Separt Sep		21 Signature of Funeral Service Licensee	Be	Name and Address of Facility 9	17 W. Isa	bella St	
	0 □ F • 0	7: 1	Justill Fill			alisbury,		
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	PNEU	MONIA			OA45
	/Medical Examiner		Due to	(or as a consequence of):	MONIA CANCEA	^		
		<u>.</u>	Sequentially list conditions, b. Due to	LUNG	CANCER	<		MONTHS
	ted nsit	Examiner	Cause (Disease or injury	(or as a consequence or).				
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89	ificate g phy as the	edic	U					
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o,	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to d				o use contribute to	the cause of death?
ğ	w require been si should b	pel	CHRONIC OBST	510N		1 DYes	2 □ No 3 □ Pro	obably 4 Unknown
Ö	e law re has be je 2 sh	Completed	CHRONIC OBST	RUCTIVE 1	ULMONARY DI	SASE 24a. Was an	24b. Were au	topsy findings available completion of cause of
<u> </u>		Com			. /	performed 1 ☐ Yes 2 ☑	death?	
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			eath (Check only one)		
Division of Vital Record	Attending Physician: r death. sctor: After this certific. by the funeral director.	၉	1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatien		Home 5 Nesidence		cify)
ŭ	ing P	ö	I Givatural 3 Cit entiting	of Injury 28b. Time of Injury Injury	Work?	28d. Describe how i	njury occurred	
Sic	tend death tor: / the f	ertification;	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
<u>∑</u>	after deatl Director: I in by the	ŧ	determined 200. Flac	e of Injury · At home, farm, str ling, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S		irai Houte Number,
_	Hospital 24 hours 2 Funeral stely filled	O	29a. Certifier 1 Certifying Physician: To th	a hast of my knowledge, death	n occurred at the time, date and pla	and due to the save	2/2) 22 4 = 22 22 22	atatad
	24 hos Fun etely	edicai	(Check only 2 Medical Examiner: On the t	pasis of examination and/or invener stated.	vestigation, in my opinion, death of	courred at the time, date	and place, and due	to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	n. Pay, Year)
	7		1119 W	1 Wh	H4824	7	11/51	2009
-	1).		30. Name and address of person who completed cau	se of death (Item 23a) (Type.		1		- /
	80		DANIEL E. MAKA		RIVERSIDE DRZ	the Sprish	ary, ms	21801
100	Sta	te	31. Date filed (Month, 1997, Year) 6 2009 32.	Registrar's Signature	Sailes			
	Registr	ar	7 2000		A. P. S. S.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

	1- For State Registrar		Certificate of	of Death	Reg.	2009	3744
Physician edical Examine	er Joyce W	inifred Brannon			2. Date of Death Month Da November 7,		3. Time of Death 1052 hrs
7	4a. Facility Name (if n	not institution, give street and number orial Hospital)	4b. City, Town, or Location of Deati Havre de Grace	h	4c. County of Death Harford	
Funeral Director	5. Social Security Nur 222-44-408		ge (In yrs. last birthday) 53	If Under 1 Year If Under 24Hr Months Days Hours Mirrs.		Corni	thplace (State or on untry Pelaware
Varyland 28a-f show any d at once.	Maruland +	Db. County Harford	10c. City, Town or Loc. Havre de G	irace			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f she notified at once	10e. Street and Numb 307 Squaw	Cowrt		10f. Zip Code 21078		Citizen of What Courted State	ntry? s of America
after death wall, or items	3 Widowed	2 Married 12. Was Decedent Armed Forces? 1 X Yes 2 1 Yes, Give Year or Dates: cation (Specify only highest grade con	15 No 16-16-924 1	As Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify: ent's Usual Occupation (Give kind of	Rican, etc.)	14. Race - Ameri White, etc. Specify: Wh	
and 2 should be filed within 72 hours and 2 should be filed within 72 hours tealth and Mental Hygiene. Item 27 is marked other than "nature traumatic event, the Medical Examire To Be Completed It.	Elementary/Second		5+) during	most of working life. DO NOT use ret ral Employee	ired)	Civil Serv	
215-0036 be filed within 7 hall Hygiene. rked other than ent, the Medica Be Comple	b vavia bran	rst, Middle, Last) INON		18 Mother's Name Windfred	e (First, Middle, Maid d Bain	den Sumame)	" '-
MD 21 nd 2 should 1 lith and Mer m 27 is mar aumatic ev	cainerine 1	e/Relationship (Type, Print) Hickey (Daughter)	19b. Mailii 307 S	ng Address (Street and Number or Squaw Cowrt, Havr	Rural Route Number e de Grac	City or Town, State	, Zip Code) nd 21078
Baltimore, MD 21215-00; permit Pages I and 2 should be filed withi Department of Health and Mental Hygiene, Important: If item 27 is marked other ti injury or other traumatic event, the Med		Cremation 3 Removal from State Other Specify:	R.A. Ferr	osition (Name of cemetery, other place) S & Co. Inc. 11/	11/2009 W		r,Pennsylva
	8	1 all	12	Name and Address of Facility 2.3 S. Washington	St., Haure	e de Grace	, MD 21078
Physician /Medical Examiner	failure. List only of Immediate Cause (Fin or condition resulting i		Cardiovascular Di		or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
ted Insit Examiner	Sequentially list condition if any, leading to imme cause. Enter Underlyi (Disease or injury that events resulting in dea	ediate Due to (or as a conse ing Cauce t initiated C.					
executed in and I - transit		d. AMENDED					
Accords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the bunal - trans. Completed by Physician/Medical E.		egnant in the 23c. If yes, outcome Live birth	2 F	etal death 3 Ectopic pregna		23d. Date of delivery Month E	day Year
signed by the detache	Diahetes Mell		n but not resulting in the	underlying cause given in Part I.	I	co use contribute to	the cause of death?
OI VICAI RECOIDS, g Physician: The law requires ufer this certificate has been sig- neral director, page 2 should be 1: To Be Completed					24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
	25. Was case referred examiner?	Hospital:	ent 2 🗸 ER/Outpatien	26.Place of Death (Check	only one)	idence 6 Other	, 1
or Attending Physician: after death. Director: After this certifi in by the funeral director. iffication: To Be (27. Manner of Death 1 Natural 5 2 Accident	28a. Date of Inju (Month, Day,Yo			28d. Describe how		•
Spital Spital hours a meral y filled		Could not be determined (Specify)		et, factory, office building, etc.	or Town, State)	al Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	(Check only 1 Cell one) 2 Me	ertifying Physician: To the best of my edical Examiner:On the basis of exam and manner stated.	y knowledge, death occumination and/or investiga	rred at the time, date and place, and ation, in my opinion, death occurred a	due to the cause(s) at the time, date and	and manner a s state place, and due to the	ed. e cause(s)
N	29b. Signature and title			29c. License number O.C.M.E.		d. Date signed <i>(Mor</i> ovember 8, 200	
		of person who completed cause of de Assistant Medical Examiner	,	et, Baltimore, MD 21201			
State	a 31. Date filed (Monti	94/Y1ar)2 2009 32 Registrar		relat			

108 Hayard

			1 - For State Registrar	e of Maryland / Depa <i>Ce</i>	artment of F			iene 9. No. 2 N N (371.1.0
	Physici		1. Decedent's Name (First, Middle, Last) Henry Tilden Cornelius	5			2. Date of Death Month October	Day Year 28, 2009	3. Time of Death 2:05pm M
	/Medio Examin		4a. Facility Name (If not institution, give street an Chestertown Nursing &	· ·	4b. City, Town, o	r Location of Death		4c. County of Dea	ath
ī	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	F 97 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7 / 7 / 19]	Year) 9. Bi	rthplace (State or Foreign Country) NJ
	r 28a-f show	irector	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Anne's 10e. Street and Number	10c. City, Town or Lo			10	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No country?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinar mast be notified at once.	d by Funeral Director	Arme 1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 13. d Forces? (es 2 100 c), Give or Dates:	21623 Was Decedent of Fif Yes, specify Cubin 1 Yes 2 No	Specify:			white
-C1717 E	iled within 72 h 1ygiene. Iher than "natu nt, he weden	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12 17. Father's Name (First, Middle, Last)	ted) (Give	edent's Usual Occup kind of work done DO NOT use retired	during most of work d)		Agricult	,
aryland	should be fi and Mental H s marked of umatic ever	To Be	Henry T. Cornelius 19a. Informant's Name/Relationship (Type. Print,) 19b. Maili	ing Address (Street	Catheri	ne Bower		Zip Code)
lore, M	ages 1 and 2 nt of Health at t: If item 27 ls or other tra		Tilden Douglas Cornel 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date 2	20c. Location - City o	r Town, State
Daltimor	permit. Pa Departme Important any injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensed	F	2 Name and Addre	ess of Facility	n & Newna	urch HI11 m Funeral MD 21620	
*	Physician		23a. Part 1. Enter the disease, or domplications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do not en on each line. ALUPE TO TI	-	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions.	e to (or as a consequence of): e to (or as a consequence of):					
,0070	icate be executed physician and s the burial-transit	dical Examiner	that initiated events c.	e to (or as a consequence of):					
O. BOX 90	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?		☐ Ectopic pregnand	cy .		23d. Date of d Month	elivery Day Year
cords, r.	quires that in signed by	1	Part II. Other significant conditions contributing Hrs Tary OF AND		ınderlying cause giv	en in Part I.			to the cause of death? Probably 4 dunknown
חשבו או שפנים	ician: The law re certificate has bee rector, page 2 sho	Completed by	Progressing De Men	lia			24a. Was ar autops perforn 1 □ Yes 2	y prior to ned? death?	autopsy findings available o completion of cause of es 2 \(\sum No
on or vital	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 ER/Outpatie Date of Injury Month, Day, Year) 2 ER/Outpatie 2 ER/Outpatie	of 28c. Injur	ner: 4 Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 □Other (Sp	pecify)
DIVISION	al or Atten s after deat al Director: ed in by the	Certification:	- Da : : : 6 D Could not be	Place of Injury - At home, farm, st building, etc. <i>(Specify)</i>			28f. Location (St. City or Town	reet and Number or i , State)	Rural Route Number,
	the Hospit in 24 hour the Funera Tpletely fills	Medical ((Check only 2 Medical Examiner: On one) and	o the best of my knowledge, dea the basis of examination and/or in manner stated.	nvestigation, in my	opinion, death occu	rred at the time, da	ate and place, and d	ue to the cause(s)
)	3	2	29b. Signature and title of certifier C. Anaba	cause of death (Item 23a) (Type,	29c. Licens	23 ff 9	29	9d. Date signed (Mo.	0/0 9
	M s	to	30. Name and address of person who completed VOHN & HRICABAL 31. Date filed (Month, Dex Year)	cause of death (Item 23a) (Type, 77, 40, 223) 32. Registrar's Signature	1togh S	treet, CH	es Lento	un, Ma	d 21620
	ાટ Registr		NOV 0 2 2009	Down B.	gara				

09-08839 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 37450 **Hector Say Cupid** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 14, 2009 1111 hrs **Medical Examiner** Hector Say Cupid 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 6701 Selkirk Drive Bethesda Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Linder 1 Year If Under 24Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. Director None Country Guatemala 1X M 2 F 35 02/21/1974 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 X Yes 2 No Md Prince George notified at once. Hyattsville hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1428 Apt. 101 Kanawah St. 20783 Guatemala Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 1 X Yes 2 No specify: Guatemala Widowed Divorced Yes, Give Yes Specify: Hispanic marked other than "natural", c event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) i. Pages 1 and 2 should be filed within 72 ltment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "1 or other traumatic event, the Medical F. College (1-4 or 5+) Baltimore, MD 21215-0036 9th Labor Landscape 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Benancio Say Jorge Be Rosa Maria Cupil Monzon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 20783 Tomas Say Cupil/Brother 1428 Kanawah St. Hyattsville 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State General Cemetery 11/28/09 Guatemala Donation 5 Other Specify John T. Phines Funeral Home 21. Si ure of uneral Service Lica 22. Name and Address of Facility 3005 12th St. NE Washington D.C. 20017 seused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate interval 23a, Part I, Enter the disease, or complications that Physician Between Onset and failure. List only one cause on each line / y edical Death Sharp force injury of neck Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause: Enter Undarlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician a for use as the burial -X UNPENDED AMENDED 23a,27,28a-f,perME g898 12/4/09 TT Box 68760. IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Records. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes ✓ Yes 2 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be u C e

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifi completely filled in by the funeral director, Division of Vital 2

examiner? Hos	pital:	DOA Other Nursi	Decidence Code Code
1 ✓ Yes 2 No	Inpatient 2 ER/Outpatient 3	DOA Otrier4 Nursi	ng Home 5 Residence 6 Other: Scene
27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 3 Suicide 6 Could not be determined	28e Place of Injury - At home, farm, street, fac	-	28d. Describe how injury occurred Subject structhis neck with chainsaw while trimming trees 28f. Location (Street and Number or Rural Route Number, City 670 Towns State) in Rural Route Number, MD
one) 2 Medical Examiner: On	To the best of my knowledge, death occurred a n the basis of examination and/or investigation, i nd manner stated.		d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
10 - 11 C IN	1	O.C.M.E.	November 15, 2009
30. Name and address of person who com	npleted cause of death (item 23a)		
Donna M. Vincenti, MD As	ssistant Medical Examiner 111 Pe	nn Street, Baltimore, N	MD 21201

Registrar DHMH 17 Rev 1/2001

OCME 2006

Medical

State

31. Date filed (Month, Day

NOV

arks

Registrar's Signatur

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item, 19a per inf 9931, 9-12-12 yr. Amend Item 25 per inf 9931, 9-12-12 yr. Amend It 1 - For A Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nov. Day 2009 Year 5, 1455 рм Charitar Motilal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2809 Lime St. 8. Date of Birth
(Month, Day Yer Temple Hills Prince Georges 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}1940 Trinidad 1 M 2□ F Hours Months Days 087-48-0328 Director 69 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Examiner is ust be notified at Director 1X Yes 2 □ No Md. Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2809 Lime St. 20748 Trinidad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 δ If Yes, Give Year or Dates 1 ☐Yes 2 ☐No Specify: 3 Nidowed 4 Divorced Swecify: Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) t 2 should be filed with and Mental Hygier 7 Is marked other the 12 Electrician Goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mano Charita Lutchmin Paul 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing-Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Jennifer Ramcharitar Jennifer Rancharitar/Daughter Health a other t Wash. D.C. 20032 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 11-12-09 4 ☐ Donation 5 ☐ Other (Specify) Riverdale , 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Mortuary, PA 0777 1409 Fairlakes Pl. Ste. B Mitchellville, Md 23a. Part 1. Enter the sease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed ON AD ROVED BY resulting in death) Last CERTIFIC burial-t Due to (or as a consequence of) Box 68760, physician Physician/Medical the ending pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the s detached f Ö 1 Yes 2 No 9 Unknown σ. nificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has 24a. Was an page 2 autopsy performed? Yes 2 No Division of Vital 1 ☐Yes 2 ☐No 1 □Yes Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 271No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐No 2 Accident filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 XCertifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) MD 035280 Dc Nov. 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave. S.E. Wash. D.C. 20032 Daniel MDGilbert E.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.0.0.0

			for State Registrar	oi waryian		epartment of t Certificate of t		and Mental Hy	gien Reg. N		3/452			
	Physicia	in/	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death			
	Medic	cal		carelli_				11	02		9:05 PM			
-	Examir ∡	ier	4a. Facility Name (if not institution, give street and no	,		4b. City, Town, o	of Death	4	c. County of Deat					
	Funeral		Jones Acres Assisted L: 5. Social Security Number 6. Sex	7. Age (In yrs. la		day) If Under 1 Year	nold If Under		of Birth 9. Birthplace (State					
_	Director		577-34-5446 1 □ M 2 ♣ F Usual Residence of Decedent	8:	3 \	rs. Months Days	Hours	Min. 08/13/	1926 Washington, DC					
	and show	ខ្ល	10a. State 10b. County	10c. City, Town or Location							10d. Inside City Limits			
	Maryla 28a-f otified	Director	MD Anne Arundel			Arnold					1 🏝 Yes 2 □ No			
	th the		10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?			
	ath wi	Funeral	1349 Jones Station Road	ecedent Ever in U.S	3	2101		zin? (Specify Vos or No.		USA	9. Birthplace (State or Foreign Country) ashington, DC 10d. Inside City Limits 1 Yes 2 No nat Country? A American Indian, White, etc. White ness Industry tic cders te, Zip Code) 19 ity or Town, State 1, MD 1 Home, Inc. MD 20722 Approximate Interval Between 1 Inc. 1 Approximate Interval Between 1 Inc. 1 Inc. 2 Inc. 3 Inc. 4 Inc. 4 Inc. 4 Inc. 5 Inc. 6 Inc. 6 Inc. 7 Inc. 8 Inc. 8 Inc. 9			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed	Forces? s 2 K No Give		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No				Black, White	, etc.			
2-0	2 hour "natu adical	plet	15. Decedent's Education (Specify only highest grade complete		16a. I	Decedent's Usual Occup Give kind of work done of	ation	of working	16b.		year 2009 9:05 PM Inty of Death e Arundel 9. Birthplace (State or Foreign Country) Washington, DC 10d. Inside City Limits 1 Yes 2 No f What Country? USA ace - American Indian, ack, White, etc. fy: White Business Industry estic me) Morders State, Zip Code) 409 1 - City or Town, State bod, MD ral Home, Inc., MD 20722 Approximate Interval Between 9 set and Death STATE OF TOWN Approximate Interval Between 9 set and Death 10d. Inside City Limits 12d Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes 2 No 10d. Inside Yes			
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ام 2	iled w Il Hygi I other	Be	17. Father's Name (First, Middle, Last)			Homemaker	18. Mothe	er's Name (First, Middle,		Domestic Surname)				
ylar	Id be I Menta arked	ပ	Ernest Jackson Weave	r			Min				rs			
Maryland	2 shou th and 7 is m traum	i	19a. Informant's Name/Relationship (Type, Print)		1	Mailing Address (Street a				or Town, State, Zip	Code)			
ē,	f Healf item 2		Helen Wimpee / Daughter 20a. Method of Disposition	20b. Pl	lace of I	OSkyway Disposition (Name of		Annapolis,		21409	Town State			
<u>m</u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	iii Otato		crematory or other place coln Cemet	· i	·		,				
Baltimore,	permit. Departr Import any inji		21. Signature of Funera			22. Name and Addres	ss of Facility	Ft. Linco	ln F	uneral H	ome, Inc.			
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yahing.	Ph sician/	W	Immediate Cause (Final disease or condition	Deme	rti	7					nset and Death			
Mr.	Medical Examiner		resulting in death) Due to	o (or as a consequi	ence of	:								
		iner	Sequentially list conditions, if any, leading to immediate Due to	o (or as a conseque	ence of	:								
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_	icate be executed g physician and is the burial-transit		resulting in death) Last Due to	o (or as a conseque	ence of	:								
3760	icate k g phys	fedic	d											
89 ×	ath certifica attending p	an/N	Zeb. Trae decedent program	utcome of pregnan		3 Ectopic pregnance	v			23d. Date of deli	/ery			
Records, P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Medical		egnant at time of de		5 Other (specify)		-		Month	Day Year			
<u>о</u> .	requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to	death but not resu	ılting in	the underlying cause giv	en in Part I.	23e. Did to	bacco	use contribute to	the cause of death?			
ds,	quires en sígr uld be	ed b						1 🗆 :	Yes 2	3 □ Pro	bably 4 🗆 Unknown			
COL	aw rec las bee	Completed						24a. Was		24b. Were auto	opsy findings available			
Re	ician: The law certificate has rector, page 2 s								rmed2	death?				
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of	ding Phys :h. After this funeral di		27. Manna of Death 28a. Date	Inpatient 2 E e of injury onth, Day, Year)	28b. Tin inji	ne of 28c, Injury	at	rsing Home 5 L Resid			W Living			
ion	ttendir death. tor: Af the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 🗆 I	No						
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manna of Death 1 Natural Suicide Accident Acci										l Route Number,				
_	To the Hospital or, within 24 hours afte To the Funeral Dire completed filled in the Total or th	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
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	ა	İ	29b. Signature and title of certifier	ratur		29c. License	number	y	29d. Da	ite signed (Month,	Day, Year)			
40	U	-	30. Hamp and address of person who completed cau	use of death (Item :	23a) (Tv	pe, Print)	001	1	-1	1000				
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	/Sne		t's Education st grade completed)		16a. Dece			ation Juring most of w	orkina		16b. Kin	d of Business	/Industry	
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9	/Medical Examiner		resulting in death)		ue to (or a	s a conseq	quence of):	50	1 7							
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Amend #11 & #18 per F. Dir. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO. Health Dept. 11/13/09 sa State of Maryland / Department of Health and Mental Hygiene 37454 Reg. No 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/2/2009 **Physician** Daniel Joseph Duffy 0114 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours XX M 2 F 81 113-20-2081 Director 7/4/1928 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examinar mast be notified at MDDirector Prince George Bowie 1 ☐ Yes 🛠 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13449 Yorktown Dr. 20715 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1946— IrVes, Give Year or Dates: 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩o Specify ģ White Specify 3 Widowed 4 □ Divorced 1966 "naturaf" Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, It a Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief US_Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Anne Maquire ဥ Joseph Duffy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jean Duffy Spouse 13449 Yorktown Dr. Department of Health Important: If item 27 any injury or other trong once. Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State 11/3/2009 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Lice 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a co /Medical uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ficate has been sit 1 ☐ Yes 2 ☐ No 3 ☐ Probably #☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 1 ☐ Yes 2 ☐ No 2. No Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) within 2 29b. Signatur 29c. License number Name and a who completed cause of death (Item 23a) (Type, Print Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 19

37455

Phy	sician
/M	ledical
Exa	miner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Marical Event and in a Local Event and one one.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and relietely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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	1 - State of Maryland / Dep	ertificate of Death	Reg.	2003	37455						
ian	Decedent's Name (First, Middle, Last) Wilson Lee Darrow		2. Date of Death Month November	Day 2000	3. Time of Death						
cal	Wilson Lee Darrow 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	1	4c. County of Death	2:00 PM						
ner	6101 Glenn Dale Road	Glenn Dale		Prince Geo	rge's						
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	(Year) Country)							
	577-30-5930 TAM 2 F 84 Yrs. Usual Residence of Decedent	mistario Bayo Mistario	Mar 14, 1	925 Mary	ľand						
	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits							
ş	MD Prince George's Glenn Dal	e			1 ☐ Yes 2 XNo						
)ire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?						
lal	6180 Glenn Dale Road	20769	US	A							
by Funeral Director	11. Marital Status 1 □ Never Married 2 🔀 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e							
by F	1 Never Married 2 Married 1 MYes 2 No If Yes, Give Year or Dates: 1943-45	1 ☐ Yes 2 X No Specify:		Specify: Whit	Δ.						
Be Completed		edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16b	. Kind of Business/Ind							
m pk	College (1-4015+)										
ပ္ပ	17. Father's Name (First, Middle, Last)	ederal Gov den Surname)	ernment								
To Be	George McMillan Darrow	Grace C	_	ien damame)							
<u>-</u>		ing Address (Street and Number or R		ty or Town, State, Zip	Code)						
	Janice E. Darrow/wife 6180	Glenn Dale Road	Glenn Dale	, MD 20769							
		osition (Name of ematory or other place)		Location - City or To	wn, State						
	4 □ Donation 5 □ Other (Specify) Final Jo	urney Crematory 1		oodbine, M							
	21. Signature of Funeral Service Licensee MO1 251 B	oing "Homesschemati everly I. Heckrot	on Service	P.O. Box	784						
- 77	23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										
	resulting in death) Due to (or as a consequence of):										
<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	SUPPRE SLOW									
nine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	HYPOTEL		1							
Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):	HYPOTEL	2510N								
ledical Examiner	d										
Med	IF FEMALE:										
ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delive Month	ry Day Year						
Completed by Physician/N	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)			,						
Y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?						
ed b	PROSTATE CANCEIR		1 ☐ Yes	2 No 3 Prob	ably 4 hknown						
plet			24a. Was an autopsy	24b. Were autop	psy findings available inpletion of cause of						
Sol			performed 1 □ Yes 2 ☑	? death?	·						
Be	25. Was case referred to medical examiner? Hospital:		ath (Check only one)		DAUGHTER'S						
٠ <u>.</u>	1 ☐ Yes 2 ☐ M6 Pospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time		lome 5 ☐ Residence		RESIDENCE						
tio	1 ဩMatural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	200. Describe flow ii	ijury occurred							
tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural	Route Number,							
č											
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)						
	Di Early of	D0061771	D6061776 NOVEMBER 6,2009								
	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)									
to	BRIND WORF MD 116 DEFENSE HOY, 31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	SUITE 400, A	NNAPOUS,	MARYLAND	21401						
te ar	NOV 0 9 2009 Since B. Ja	backer									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08689 State of Maryland / Department of Health and Mental Hygiene Ruth N. Duffany 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 8, 2009 1312 hrs Duffany Ruth N. **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Lanham **Doctors Community Hospital** If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country)Oak Park Months Days Min. 6-13-1946 Hours 355-38-5629 63 Director M Usual Residence of Decedent 10d_inside City Limits 10c. City, Town or Location 10a. State 10b, County 1X Yes 2 No MD Prince George's Greenbelt Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and the state of Health and Mental Hygiene, and "natural", or items 23a or 28a-f sho or onlier than "natural", or items 23a or 28a-f sho or other tranumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 6004 Springhill Drive Apt 101 20770 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X No Yes Specify: White Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 X Widowed 5 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorriane Ulfeng æ Laurence Kjelstad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Prince Frederick, MD 20678 John L.P. Duffany (Son) 2440 Fawn Court 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Cremation 3 Department of Fort Lincoln Cemetery 11/16/2009 Brentwood, MD Donation 5 Other Specify 22. Name and Address of Facility Ort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, MD 20722 3401 Bladensburg Rd non 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Physician Between Onset and /Medical Death Diabetic ketoacidosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 23a,27,28a-f,permE, g900 2/25/10 TT Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atter Yes 2 ✓ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. <u></u> Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available has been prior to completion of cause of autopsy death? performed? s certificate h ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA this 1 Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 Natural Yes 2X No Pending To the Funeral Director: 11/8/09 Fd 12:01 10m Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6004 Spring Hill Rd Apt 101 Greenbelt MD 28e. Place of injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide house determined Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital 24 hours after death.

Medical 29b. Signature and title of certifie Pamela E. Southall, MD

State

half, MU

and manner stated.

29c. License numbe O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d, Date signed (Month, Day, Year) November 9, 2009

30. Name and a oress son who completed cause of death (Item 23a) **Assistant Medical Examiner**

111 Penn Street, Baltimore, MD 21201

32, Registra Signa

21

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 3, 2009 ABBIE R. ELLSWORTH 1948M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2653 Norbeck Road Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Feb. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1959 Maryland 1 □ M 2 🗓 K 220-82-9704 50 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show r than "natural", or Items 23a or 28a-f sho MD Director Montgomery Silver Spring 1 ☐ Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2653 Norbeck Road 20906 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Specify <u>გ</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Joseph J. Wheeler Ruth Slimmer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig L. Ellsworth (Husband) 2653 Norbeck Road Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses E. Na uctis 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do nowenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SANYXICA /Medical ue to (of as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) attending physician certificate be Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy The certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred Injury 1 □ Natural 5 Pending investigation thin 24 hours after continued to the Funeral Director; A 5014 1 □Yes 2 □No 2 Accident Nov 3 2009 10 K 28f. Lo. Ton (Sireet and Number or Rural Route Number City or Town, State) 2 (53 No. Watch C 6 Could not be determined 3 X Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 140 mc mp Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.0. Division of Vital Records,

Box 68760,

Baltimore, Maryland 21215-0036

To the within

State Registrar

(Check only

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 1000410 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 37458 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year RICHARD H. FOX 4:20A^M 27, 200 4c. County of Death 2009 /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min 82 Director 077-28-6177 9/8/1927 Dansville, NY Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Middeal Eventing must be notified at 10d. Inside City Limits Director 1 ☐ Yes 🎗 🕄 No DE New Castle Townsend 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 381 Old State Road 19734 USA Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? ↓ Yes 2 No 1 Never Married 2 Married 10 Yes 2 Maryland 21215-0036 1 □Yes 2√Xo þ Specify. White Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) filed withir I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i. Pages 1 and 2 should be filled wi trnent of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, In. Field Representative Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Fox ၀ Catherine Fries 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys V. Fox/Wife O. Box 299, Odessa, DE 19730-0299 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If itel
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old Bohemia Cemetery 10/30/09 Warwick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. Let only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** neumoma disease or condition resulting in death) */Medical Due to (or as a consequence of) Examiner Stock Liver Disease Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical as use IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day 5 Other (specify) ☐Yes 2☐No O 9 Unknown 9 Unknown þ σ. s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate ! 1 ☐Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Nation 2 I ER/Outpatient 3 I DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation ours after death.

neral Director: #
filled in by the for 1 ☐ Yes 2 ☐ No death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 06918 HOSPITALIST 7 + 130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 BON Street Elkton SAMAM TAMMAY 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 27 SYSAN REBECCA OWERS OCTOBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HOSPITAL CENTER
6. Sex 7. Age //n vie hos high KENT CHESTER RIVER

5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Yrs. 7/25/1948 217-52-0829 MD 61 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Model.

Once. 1X Yes 2 □ No Director MD Kent Millington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21651 USA 209 S. Crane St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2x No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wallace ဂ္ဂ James Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8589 2nd St. Lincoln, DE 19960 Sharon M. Sewell/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/30/09 Millington Asbury Millington, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
370 W. Cypress St. Millington, MD 21651 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CANCER LIKLEY PRIMARY LUNG MONTAS Physician disease or condition resulting in death) */Medical Due to (or as a consequence of): DAYS Examiner RENAL PAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit SEPSIS Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBSTRUCTIVE PULMONARY Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 🖹 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Klamen OCTOBER 27 2009 1) 66 441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON STREET, EASTON, MD 21601 3 2195 Kolli, Ramely MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

REBECC

LOWERS

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0745 Franklin Greenwood October 2009 James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kent Chester River hestertown HOSPital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Sex 1☐M 2☐ F Hours Days 220-01-9389 93 **Director** 6/28/1916 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Modical Examinational to notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland | Kent Still Pond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13180 Still Pond Rd 21667 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 ∏xNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2 ☐No Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Welding/Painting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ James Carson Greenwood Ethel Meeks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Greenwood 11490 Still Pond Rd Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Pond Cemetery 11/5/09 Still Pond, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home expelleur 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterio Scherotic Cardio Vescular Discase **Physician** >10grs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACHO 1976 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1/2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15 D0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Charter fown MD 21620 NeilStoddavd MD

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 126 PM Andre NOVEMBER 2009 Gilmore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham
If Under 1 Year | If Under 24 Hrs. Prince Georges Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 212-78-4578 Director 48 Jan 28 1961 Baltimore, MD Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Example instituted at 1∏Yes 2∏No Directo Maryland | Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13204 Ovalstone Lane 20720 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Black þ, 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unk. s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th <u>Unk</u>, Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be D.J. Gilmore Thelma R. Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr.
once. D.J. Gilmore (Father) 2100 Koko Lane #16 Baltimore, MD 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 11/9/2009 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of uneral Service Licensee ens 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Vunknown Completed RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? certificate CEREBELLAR LNFARCT 1 ☐ Yes 2 ☐ No 1 □Yes 2 **N**O Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 61552

EVIN 31. Date filed (Month, Day, State NOV 0 9 2009 Registrar

30. Name and address of person

8118 GOOS LUCIC ROAD LANHAM, MD 20106 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** William 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SALS SUR FINE Wicomico WAY 9. Birthplace (State or Foreign Gountry) Date of Birth (Month, Day, Year) If Under 1 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 M 2 □ F -4-238-32-0736 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1ÆYes 2 No Director MARYON WICOM'S HRO 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 213 2180 WSA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 20 No Specify Specify: Black <u>چ</u> 3 Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, NONE College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ira III any once. LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EAR biteh 5 AC ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship_(Type. Print) GRENADA DOEIS (DAWSON TRICE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 Removal from State HEBROW, MARYLANO 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility SALC. MC HOME 821 WEG FUN SHIDE Approximate Interval Between Onset and Death 23a art 1. Inter the disease, or complications that ause show, or heart failure. List only one cause in each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final mase or condition resulting in death) **Physician** /Medical consequence of): Due to (or # Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnent at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐Yes 2 ☑No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide

State Registrar

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

D.

NOV 06

Medical

and manner stated

100 ERS-

32. Registrar's Signature

30. Name and address of person who concleted cause of death (Item 23a) (Type, Print)

iaylor

1 M. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	Physicia /Medic				orth Grin		Sr.							1,	2009		2:32	P M
)	Examin	er	4a. Facility Name (/	f not institution ampton	n, give street and i Manor Ni Eeenth St	number) I rsi r	ig Ho	ome		City, Town, or Location of Death					4c. County			
	Funeral Director		5. Social Security N 217–28–6	lumber	6. Sex 1 M 2 □ F	7. Age		last birthday Yrs.		reder ler 1 Year s Days		r 24 Hrs. Min.	8. Date of B (Month, July	Birth Day Ye		derio	c <u>k</u> place <i>(State</i> ntry) irylar	or Foreign
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permi	perimit. Tages I and 2 should be mad writin 2 frous Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, if a Madical Ex- once.		21. Signature of Fu	Signature of Fundral Service Licensee 22. Name and Address of Facility Robert E. Dailey & Son F.H. PA. 615 East Main Street, Thurmont, MD. 21788														
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Attending Physician: The law requires that the death certificate be	s been signed by the should be detached	by P	Part II. Other signif	ficant condition	ons contributing to	death bu	it not resi	ulting in the	underlying	g cause giv	en in Part	I.	23e. Di	d tobac	co use con	tribute to t	he cause o	f death?
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he Ho	n 24 h	Medical	(Check only one)	2 Medical	Examiner: On the and m	e basis of anner sta	examina ted.	ation and/or	investigat	on, in my o	opinion, de	eath occur	red at the tim	ne, date	and place,	and due	to the cause	
5	Solution 1	Ž	29b. Signature an	ttle of certifie	r				1	29c. Licens	e number	2		29d.	Date signe	ed (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

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al er	4	. Facility Name (If not institutio			nber)		4b. City,	Town, or Lo	ocation of Dea		ODCI	_	ounty of Death	
		1776 Old Teles	raph	Road			Warw	rick				C	ecil	
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To Be		George Washing	rton B	ovla:	c			F	lmma Ma	ız Çmi	+h			
		9a. Informant's Name/Relations			<u> </u>	19b. Ma	ailing Address					; City or	Town, State, Z	Zip Code)
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	20	Da. Method of Disposition 1 → Burial 2 ☐ Cremation	3 D Berne	oval from 9	State 20	b. Place of Dis cemetery, c	sposition (Nar crematory or o	me of other place)	1	Date		20c. Loca	ation - City or	Town, State
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	21	Signature of Funeral Service	Licensee	.11			22. Name ar	nd Address	of Facility				1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELLA LOUISE HART NOVEMBER 5, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CIVISTA CHARLES MEDICAL CENTER LAPLATA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex f Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (St. MARCH 17, 1923 MARYLAND 9. Birthplace (State or Foreign Days 1 □ M 2 🙀 F 217-30-3002 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND **CHARLES** 1 X Yes 2 □ No INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 WOODLAND DRIVE 20640 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ∐Yes 2. If Yes, Give Year or Dates: 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE EXPLOSIVE OPERATOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GILBERT HART DAISY HART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE CHASE / DAUGHTER 108 WOODLAND DRIVE, INDIAN HEAD, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ALEXANDRIA CHURCH CEM, NOV.11, 2009 RISON, MARYLAND 4 Donation 5 Dother (Specify) THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 200 1 □ Yes 2 E No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 121Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1116109 D45

Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760. Division of Vital death. after death filled in by 24 hours a within 2 To the I

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Completed by Physician/Medical

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ical Certification: To

Funeral

Director

Department of Health and Mental Hygiene. Important: "or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours

21215-0036

Baltimore, Maryland

FL

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIRMALADEVI JAYANTHAN, M.D., 3328 OLD WASHINGTON RD, WALDORF, MD. 3. Registrar's Signature

ORIGINAL

			For State Registrar	State of	Maryland / De	partment of l ertificate of		i Mental Hy	rgiene	9 371.66
	Physici	an	1. Decedent's Name (First, Mic	4.4				2. Date of De Month	Dav Year	3. Time of Death
44	/Medic	cal	4a. Facility Name (If not institut	Hutchin		Ab City Toyen	or Location of De		er 29, 2009 4c. County of De	2:20 p M
	Examin	er	Shady Grove A			Rockv				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	rth 9. B	irthplace (State or Foreign
	Director		238-50-3275	1□ M 2⊠ F	73 Yrs.	Months Days	Hours Mi	rs. 8. Date of Bir in. (Month, Da August	17, 1936 N	orth Carolina
	and		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town or	Location				10d. Inside City Limits
	Maryl.	ţ		tgomery	Damas					1 ☑ Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	23a c	ral	24413 Ridge H	Road		2087	2		United	States
	er dea	Funeral	11. Marital Status	Armed For	dent Ever in U.S. 1 ces?	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	0- 14. Race - An Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divorc	If Yes Giv	e	1 ☐ Yes 2 X No	Specify:		Specify:	The district
21215-0036	2 hou	ted	15. Deced	lent's Education	16a. De	cedent's Usual Occu	pation		16b. Kind of Busines	hite s/Industry
218	thin 7 re. ran "n	Completed	(Specify only high Elementary/Secondary (0-12	thest grade completed) College (1-	40r 5+)	ve kind of work done o. DO NOT use retire		vorking		
2	filed within I Hygiene. other than ent, It e M		12	(- 1 - 4)	U	nobtainab		/Final 841441	C.I.A.	
anc	thould be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, it a five dictal Examiner must be rediffed.	Be C	17. Father's Name (First, Midd. Tellis	Carswell					e, Maiden Surname)	
Maryland	nd 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show rtraumatic event, it a Medical Examiner must be rediffed at	욘	19a. Informant's Name/Relatio		19b. Ma	niling Address (Stree	Hester		Poteet Der, City or Town, State	Zip Code)
	elth a 27 Is 27 Is		Donna Hutchin			.3 Ridge R				, – ,
ore,	es 1 a of He of He filtem		20a. Method of Disposition	- 0 - B	20b. Place of Dis	position (Name of rematory or other pla	ice)	Date	20c. Location - City of	r Town, State
Ĕ	Pagiment ment ant: I		1 ☐ Burial 2 🛣 Crematio 4 ☐ Donation 5 ☐ Other		otate	oln Crema		/5/2009	Brentwo	od, MD
Baltimore,	permit. Pages 1 and 2:3 Department of Heelth a Important: If Item 27 Is any Injury or other trau		21. Signature of Funeral Servi	ce Licensee)	22. Name and Addr		Simple Tr		
	TD = 0 0		23a. Part 1. Enter the distere,	or complications that as					ville, MD 2	0852 Approximate
	Discount of the		shock, or heart failur. L	ist only one cause on ea	ach line.	enter the mode of dy	ing, such as card	nac or respiratory a	arrest,	Interval Between Onset and Death
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	Examiner				1027 (nsion					hours.
2	bit iit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequence of):					
5	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):					hours
8760,	ate be ex hysician he burial	icalE	3 222, 2	1						NO115
687	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edic		d	ng conce					, , , , , , , , , , , , , , , , , , ,
Box 68	eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	3 □ Ectopic pregnan			23d. Date of d	lelivery
_	ie deat the att ned for	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No		ant at time of death	5 ☐ Other (specify)			Month	Day Year
P.0.	that the do	Phy	9 ☐ Unknown Part II. Other significant cond				von in Doet I	220 Did	tobacco use contribute	to the source of death?
of Vital Records,	signe signe d be c	d by	rait ii. Other significant cond	intons contributing to de	attrottesuiting in the	e underlying cause gi	ven in Fait i.			Probably 4 Unknown
50	law requir as been s 2 should	Completed						24a. Was		autopsy findings available
æ	The far cate has page 2	E C						auto perfe	opsy prior to formed? death	o completion of cause of ?
ita	lclan: Th certificate ector, pag	BeC	25. Was case referred to medi	cal		· · · · · · · · · · · · · · · · · · ·	26. Place of D	1 2 Yes Death (Check only		es 2 No
>	ding Physician: n. After this certific funeral director,	To E	examiner? 1 ☐ Yes 2 🔀 No		npatient 2 ER/Outpa	tient 3 DOA Ot	her: 4 \(\sum \) Nursing	g Home 5 ☐ Res	sidence 6 Other (S)	pecify)
n	Jing P. After t	ii O	27. Manner of Death 1 ♠Natural 5 ☐ Pend		of Injury 28b. Time h, Day, Year) Injur	y Wo		28d. Describe	how injury occurred	
Division	death. ctor: A y the fu	icat	3 ☐ Suicide 6 ☐ Cou	stigation	of Injuny - At home farm	1	⊒Yes 2□No	29f Location	(Street and Number or	Dural Pauta Number
ο̈́	after after Direction by	Certification:	4 ☐ Homicide dete	ermined 20e. Flace building	of Injury - At home, farm, ig, etc. (Specify)	street, lactory, emice		City or To	own, State)	nurar noute Warnber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	edical C	29a. Certifier 1 Certification (Check only one) 1 Medic	rying Physician: To the cal Examiner: On the ba and mann	best of my knowledge, do asis of examination and/o er stated.	eath occurred at the rinvestigation, in my	time, date and pl opinion, death o	ace, and due to the courred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	Vithin Vithin Comp	Me	29b. Signature and title of cert			29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
-	10) //		MA-	\$ 0	59267		04. 2	9 2009.
			30. Name and address of pers	on who completed cause		e, Print)				g 2009.
	- 0		Lawrance 31. Date filed (Month, Day, Yes	J. 1914	(CUI+Z MD	2101	Nedical	fark Do	.vr Silv	o sping.
	Sta Registr		NOV 06	2009 2	egistrar's Signature	wed.				
				100.						

Registrar DHMH 17 Rev 1/2001

Division of Vital Records, an 24 hou. Le Funeral P

To the

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 32. Registr 0 2009

Brame 9

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 2, 2009

29a. Certifier 1

29b. Signature and titl

Medical

State

Registrar

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			Registrar Amend#11.PerFH	CC11-16-	-09ar	Cer	uncau	e or L	Jealii		2. Date of Deat	eg. No. h		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)								Month 1 1	Day	Year 2009	8:19 A M
	/Medic	al	Willie R. Ha			•	4b. City.	Town, or	Location of	of Death	11		nty of Death	0.19 A
	Examin	er	Gladys Spellman				Н	vat	tsvi.	11e		Pri	nce G	eorges
-	Funeral		5. Social Security Number 2 6. Sex		. Age (In yrs. la		If Under		If Under		8. Date of Birth		0 Dietho	lana (State of Foreign
	Director		577-48- 9782 1	M 2□F	73	Yrs.	Months	Days	Houis	IVIII.	09-03-	1936	So.	Carolina
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	anyla shov	ا ۾						D	~					1X Yes 2 □ No
	28a-f	Director	DC		VV	ashin	10f. Zip		· C ·		1	0g. Citizen	of What Coun	ntry?
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	death with the Maryland me 23a or 28a-f show Enwal be rediffed at	Funeral		2. Was Deced	lent Ever in U.S	5. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Americ	
	or Ite	교	1 ☐ Never Married 2 X Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	No.		1 ☐ Yes		Specify:		noun, oto.,			lack
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א ס	be filed ntal Hygic od other event, I		17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Sun	name)	
Maryland		To Be	Willie R. Hami	lton.	Sr.				Wi	1he1	mina F	10110	wav	
a Z	Should had had had had had had had had had ha		19a. Informant's Name/Relationship (Type			19b Maili	ng Address	(Street a	and Number	n or Bura	Route Number Penue	r, City or To	wn, State, Zip	Code)
	and 2 ealth a m 27 ie		Rufus Hamilton	(Brot	her)	Cap	itol	. He	ight	S, N	Marylar	ıd	20743	
Ĕ	of He of Herr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emovat from S	tato CE	ace of Dispo emetery, crea	matory or c	other plac			Date		on - City or To	
Ĕ	Pages ment of ant: if it ury or o		4 ☐ Donation 5 ☐ Other (Specify)		MD	Nat.			-				rel,	
Baltimore,	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Servine License	Olive-	T	2 K	a 1ph 3202	nd Addres Wi Pri	s of Facili Ilia ncet	ms,] onDe	I Fune	ral r.Bo	Servi wie,M	ce, P.A. D 20720
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that ca	used the death									Approximate Interval Between Onset and Death
M. E.	Physician		Immediate Cause (Final disease or condition		stroin	testi	na1	Ble	edin	g				Oliset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):								
	Examiner	_	Sequentially list conditions,	Section 4	or as a noneequ									
	ed sit	line	cause. Enter Underlying Cause (Disease or injury	20310 (A SE S COLISON	301 H/3 U4)								
	and and al-tran	Examiner	that initiated events resulting in death) Last		or as a consequ	uence of):								
760,	ate be executed hysician and the burial-transit	cal		l										
89	tificat ig phy as the				_					-				
ŏ	leath certific attending p	Physician/Med	23b. Was decedent pregnant		ome of pregna		⊒Ectopic p	regnancy	,			23d.	. Date of deliv Month	ery Day Year
.O. Box	b deal	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de		Other (s	pecify) _						,
<u>a</u>	that the de ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions cor	stributing to de	ath but not resi	ulting in the I	ınderivina	ralise div	en in Part	I.	23e. Did to	bacco use	contribute to	the cause of death?
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S	w require s been si should b	Completed	Chronic Renal	Failu	re						24a. Was autop	an 2	4b. Were aut	opsy findings available ompletion of cause of
æ	Physician: The lav this certificete hes al director, page 2	E									perfo	rmed?	death?	
ta	rtifice	BeC	Respiratory Fa	llure					26. Plac	e of Deat	h (Check only o			
>	hysic his ce I direc	2	I Tes 2X NO	_	npatient 2				4 14 14	ursing Ho	me 5 Resid			rfy)
Ē	ing Pl		27. Manner of Death 1 1 1 1 1 1 1 1 1 1	28a. Date of	of Injury h, Day Year)	28b. Time o Injury		28c. Injur Wor		TNO	28d. Describe h	now injury o	ccurred	
Sio	Attending in death.	cati	2 Accident investigation 3 Suicide 6 Could not be	One Place	of Injury - At he	omo form c	M Iront facto		Yes 2 □	1140	28f Location /5	Street and N	lumber or Rui	ral Route Number,
Division of Vital	after of Direct	Certification:	4 Homicide determined		ng, etc. (Specif		ileel, lacio	ry, onice			City or Tov			
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the ner: On the ba and manr	asis of examina	wledge, dea ition and/or i	th occurred nvestigatio	d at the til	me, date a opinion, de	ind place, ath occur	and due to the red at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within ? To the comple	Me	29b. Signature and title of certifier				29	c. Licens	se number			29d. Date s	igned (Month	, Day, Year)
	- s - ō		1 Lating	181	4			D0	0260	24		11	- 5-	2009
1	(30. Name and address of person who co	ompleted caus	e of death (Iten	n 23a) (Type	, Print)							
V	<i>></i>		Lester Miles	, MD	1160	Varr		st.,	N.E.	Was	shingto	on, D	.C.	20017
		ate	31. Date filed (Month, Day, Year) NOV 1 0 2009	32. R	egistrar's Signa	ature					~			
	Regist	rar	MATASONS		L. L.									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State RegistrarAmended#20b	State of Mary		artment o <i>rtificate d</i>	f Health and of Death 11/	Mental Hyg 5/09	giene 200	9 37470
I	Physici		Decedent's Name (First, Middle, Las VERA MAY H	ORINE				2. Date of Dea Month NOV,	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give NORTHAMPTON MAN			4b. City, Iow FRED	n, or Location of Deat ERICK		4c. County of De FREDER	ath CK
	Funeral Director		5. Social Security Number 293–18–0976	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birtl (Month, Da) MAR 23	h Year) 9. B	irthplace (State or Foreign Country) HILO
	yland now		Usual Residence of Decedent 10a. State 10b. County Frederic	1- 100	City, Town or Lo	cation				10d. Inside City Limits
the Mary 28a-f sh		Director	MD Frederic 10e. Street and Number	K	riedei.					1 ∑Yes 2 □ No
	23a or	ral Dir	149 FAIRVIEW AV	ENUE		10f. Zip Coo 217			10g. Citizen of What C	ountry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modral Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent f Yes, specify (1 □ Yes 2 🛣	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)		nerican Indian, ite, etc. NHITE
21215-0036 d within 72 hours aff gjene.	in 72 hc	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Oo kind of work do DO NOT use re	ne during most of wo	rking	16b. Kind of Busines	s/Industry
	ed withi lygiene. ner thar	Com	Elementary/Secondary (0-12)	College (1-4or 5+) 4 YEARS	1	OOL TEA	CHER		EDUCATIO)N
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, tre	To Be	17. Father's Name (First, Middle, Last) BENJAMIN MAXSON	Ī			18. Mother's Nar NETTIE		Maiden Surname) THORST	
Mary	12 should I th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (7 CARROLL L. HORIN		ľ	-			er, City or Town, State	
Baltimore,	permit. Pages 1 and 2 Department of Health important: if Item 27 i any Injury or other tra once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Ob. Place of Dispo	sition (Name o	CTERY ++	Date	20c. Location - City of FREDERICK	or Town, State
Balti			21. Signature of Pupical Service Licen	TERAL HOMES						
	Physician	5 10	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lic diops hat caused the construction use on each line.	death. Do not ent	Grand	us Colit	tis	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	Ovar	ian Can	nen		year
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	Due to (or as a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical E	resulting in death) Last	Due to (or as e cor	nsequence of):					
O. Box	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 [Ectopic pregn Other (specify			23d. Date of d Month	lelivery Day Year
s, P.	res that signed b be deta	ρ	Part II. Other significant conditions co	entributing to death but not	t resulting in the ur	nderlying cause	given in Part I.	23e. Did to		to the cause of death?
corc	w requir s been s should	leted						1 □ Y		Probably 4 Unknown autopsy findings available
of Vital Records,	: The lav icate has	Completed						autop	sy prior to rmed? death?	completion of cause of
Vit	Physiclan: Th r this certificate ral director, pag	Be	25. Was cese referred to medical examiner?	Hospital:		[Others	ath (Check only or		
	Physer this eral dir	۲: T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time of	1 3 DOA	4 Nursing F		dence 6 Other (Sp	pecify)
Division	Attending Ph death. ctor: After th y the funeral	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Yea	ar) Injury	١ ١	Vork? 1 □ Yes 2 □ No		,,	
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (Si	pecify)			City or Tow		
	he Hosi n 24 ho he Fune pletely (Medical	29a. Certifier (Check only one) 1	vsician: To the best of my iner: On the basis of exa- and manner stated.	/ knowledge, deatl mination and/or in	n occurred at the vestigation, in r	ne time, date and plac my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2		29c. Lic	ense number		29d. Date signed (Mo.	nth, Day, Year)
	5		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)	tre, Fr	edench	29d. Date signed (Mo.	2174/
ľ	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature A.	barre	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 ever 101 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Hour umbi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 Director 54 23, 1955 Maryland 217-66-8981 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show or items 23a or 28a-f show draw must be notified at Funeral Director 1 ☐ Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12473 Quail Woods Drive 20874 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 X No þ Specify Specify: 3 ☐ Widowed 4 🌠 Divorced White "naturai" Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, its integles 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper/Accountant Production Comany 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lester Sylvester Garlick Mary Katherine Watkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. partment of Health ar Important: if item 27 is any injury or other traus Stacey R. Birdsall, daughter 7852 Tick Neck Road, Pasadena, Maryland 21122 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Sunset Memorial Park 11/7/2009 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part i. En er the disease, or complications mal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or leart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atmschaha Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? in the past 12 mon 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perforr certificate 1 □Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No hours after death. the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and addre ompleted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

3

3605

Registrar's Signature

2009

09-08869 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jaron Michael Ivey State of Maryland / Department of Health and Mental Hygiene 2009 37472 1- For State Certificate of Death Reg. No. Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 15, 2009 1136 hrs Medical Examiner Jaron Michael Ivey 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick 1336 Taney Avenue #301 Frederick 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Min. Director Country) Maryland 1 X M 2 Sept. 1,1991 18 217-33-0008 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 No 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Walkersville Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21793 United States 124 Capricorn Drive Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: White ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) High School Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the Be Stephanie Boone <u>Paul Ivey</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ 19a. Informant's Name/Relationship (Type, Print) 2 124 Capricorn Drive, Walkersville, Maryland 21793 Stephanie Egan/ Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/20/2009 Walkersville, Maryland Donation, 5 Other Specify Glade Cemetery rvice Licensee 22. Name and Address of Facility
Stauffer Funeral Homes P.A. 21. Signature of Funeral Se 1621 Opossumtown Pike, Frederick, Maryland2170 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a.Alcohol & Buprenorphine intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical physician a X UNPENDED AMENDED 23a, 27, 28a-f, permE, g898 12/2/09 TT Box 68760. IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ \$ Yes 2 No 3 Probably 4 ✔ Unknown σ, Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician; Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes ٩ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27 Manner of Death Certification: Natura¹ Yes 2 X No Pending Director: unk 11/15/09 Fd 11:30 am Fd2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1336 Taney Ave. #301 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) Found: private dwelling To the Funeral Frederick, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 16, 2009 O.C.M.E.

Registrar
DHMH 17 Rev 1/2001
OCME 2006

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2009

Assistant Medical Examiner

Registrar's Signatu

ENERAL

Ling Li, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3Pr 2009 7:00A Alexander Gray Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Queen Anne's Chestertown 205 Boundary Ave. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1x M 2 □ F Days Months Hours Director 218-20-7835 Maryland 25 March Usual Residence of Decedent Show Department of Health and Mental Hygiene. Important: If items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Directo Queen Anne's Maryland Chestertown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21620 205 Boundary Ave. 12. Was Decedent Ever in U.S. Armed Forces?
12 Yes 2 No
15 Yes, Give 45-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 45-46 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Law Attorney 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Sally Waterman Gray Edgar Alexander Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Boundary Ave. Chestertown, Maryland 21620 Catherine M. Jones/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Cntr. 11/2 Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility rik & Fellows, Helfenbein, &Newnam FH Chestertown, MD 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause or each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending M 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of

Name and address of person who

srew) 31. Date filed (Month, Dev. Year)

ĺ 5

death (Item 23a) (Type

32. Regi

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Katie Clark Jenkins ODAM 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 N. Main St., Apt. 107 Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, 1 □ M Months Days Hours Min. 222-20-7886 3/1/1908 Director 101 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Incition Exemine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Funeral Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 N. Main St., Apt 107 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Be Completed by 1 □Yes 2 No Specify: Specify: White XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Henry Clark မှ īva Maude Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Jenkins/Son 16851 Hayes Landing Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVEYGREEN COME CAY 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/8/2009 Berlin, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Burbage Funeral HOme 108 William St. Berlin, MD 21811 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) pulnonth 4011 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an 1 ☐Yes 2 ☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BA6

State Registrar

NOV 0 6 2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygieney 37475 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** KUEHNLE MARION 0136 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Heron Point Chestertown Kent If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 ☐ M 2 🕱 F 90 3/13/1919 Director 074-12-1070 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Heelth and Mental Hygiane. Intem 27 is marked othar than "natural", or iteme 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiane. 27 is marked other then "natural", or lieme 23e or 28e-f ehow traumatic event, the Medical Exportment must be notified at 14 Yes 2 □ No Director Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Heron Point 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∆ Yes 2 □ No
If Yes, Give
Year or Dates: 43-44 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ignats Kotko Anna Savich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Rowley/daughter 497 Barlett Dr. Willow Springs, MO 65793 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 11/6/09 Stevensville, MD 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAILURE TO THRIVE months /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical es the attending for use es IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown OPSTPLUCTIVE PULMONARY s peen s LUMBAR SPONDYLOSIS 24b. Were autopsy findings available prior to completion of cause of death? SEVERE 24a. Was an autopsy performed certificate 1□Yes 2√No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 2 ER/Outpatient 3 DOA After thi 27. Manner of Oeath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0041587 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown, MD Z S Decr 32. Registrar's Signature 122 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State #20a,20b,20c, M.S., Kent Co. Certificate of Death Amended 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 28, 2009 October 11:00p M Lucile F. Kennedy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Manor Chestertown Kent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8/23/1918 Birthplace (State or Foreign Country) **Funeral** Hours Days Min. 1 □ M 2 F 219-60-1566 Director New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2∏No Director Maryland Kent Still Pond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12715 Still Pond Road 21667 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse <u>Health</u> Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin R. Fellows Grace Ruland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Kennedy daughter 21667 O. Box 24 Still Pond, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ∑5 ☐ Other (Specify) Still Pond Cemetery Chesapeake Cremation 10/31/09 Still Pond, MD Stevensville, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, MD 21620 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dehndration disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy been signed by the atter-should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: A Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 completed cause of death (Item 23a) (Type, Print)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Examir	ner	4a. Facility Name (If not institut MONTGOMERY			L	OLNE	EY	Deatti			TGOM	
Funeral Director		5. Social Security Number 225–35–9264	6. Sex 1 X M 2 ☐ F		yrs. last birthday) Yrs.	Months Days		4 Hrs. 8. Date of (Month, JULY	Day, Yea		9. Birthp Coun GHAN	
2		Usual Residence of Decedent 10a. State 10b. Coun	rgomery		c. City, Town or Lo						11	0d. Inside City Lin
a or 28a. be notif	Direc	10e. Street and Number			OTDATK D	10f. Zip Code			10g.	Citizen of V	What Coun	try?
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29c. License number **D68658** 29d. Date signed (Month, Day, Year) 11/1/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 PRINCE PHILLIP DRIVE OLNEY, MARYLAND 20832

State Registrar

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yson Edward I	1- R	For State Certificate	of Death	Reg. No. 2009 374 7
Physiciar dical Examin	-	. Oecedent's Name (First, Middle,Last) Grayson Edward Kenney Jr.		November 2, 2009 Year 0737 hrs
	1	a. Facility Name (if not institution, give street and number) 3521 Tulsa Road	4b. City, Town, or Location of Oeath Gwynn Oak	4c. County of Death Baltimore County
Funeral Director		6. Sex 7. Age (In yrs. last birthday 221–56–2208 1 X M 2 F 46	/) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Yrs.	8. Oate of Birth (MM/00/YYYY) 9. Birthplace (State or Foreign Country) May 29, 1963 Maryland
		Jsual Residence of Oecedent		10d. Inside City Limits
ınd show any nce.	- 1	MD Baltimore County Baltimore	ce	1 Yes 2 X No
e Maryland or 28a-f show fied at once.	Director	3701 Twin Lakes Court	10f. Zip Code 21244	10g. Citizen of What Country? USA
	L	11. Marital Status 12. Was Oecedent Ever in U.S. 13. Naver Married 2 Married Armed Forces?	i. Was Oecedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
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1215 d be filed lental Hy narked of event, th	8	Gravson Edward Kennev Sr.	n D. Hopkins tural Route Number, City or Town, State, Zip Code)	
MD 21 d 2 should I th and Men n 27 is man	٩	Victoria K. Mitchell/Sister 76	526 Fentral Avenue	- Salisbury, MD 21801 Oate 20c. Location - City or Town, State
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Baltin permit. Pa Departmen Importan injury or	1	4 Donation 5 Other Specify: Springni 21/Signature of Funeral Service Licensee	22. Name and Address of Facility Sa	lisbury, Maryland 21801
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Box 68760, e death certificate be exe the attending physician a ed for use as the burial -	S.	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	Other (Specify)	
Records, P.O. Box The law requires that the death icate has been signed by the arte page 2 should be detached for u	by Phy	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Oid tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Vital Records, P.O. B hysician: The law requires that the dothis certificate has been signed by the Idrector, page 2 should be detached				24a. Was an autopsy prior to completion of cause of
Recor	Completed			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital Records, ng Physician: The law require this certificate has been so neral director, page 2 should I	o Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Out	26.Place of Oeath (Check patient 3 OOA Other, Nursi	ng Home 5 Residence 6 ✓ Other: Scene
of ng P	-		me of Injury 28c. Injury at Work? hrs 1 Yes 2 • No	28d. Oescribe how injury occurred Subject shot
Division tal or Attendi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3521 Tulsa Road , Gwynn Oak , MD
Division of Vital Prother Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		4 W Homicide determined (Specify) Other (driveway) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, an	d due to the cause(s) and manner as stated.
To the II within 24 To the F	Medical	one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s) 29d. Oate signed (Month, Day, Year)
. ₩	Σ	29b. Signature and title of certifier At Landschott	O.C.M.E.	November 3, 2009
THEN		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21	201
	tate	31. Oate filed (Month, Day, Year) 32. Registrar's Signature	Sparke	
Regis	tra	NOV 0 6 2009 Leneur B.	7	

OHMH 17 Rev 1/2001 OCME 2006 09-08474 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 37479 Thapelo Andre Kwofie State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day November 1, 2009 Year 1550 hrs **Medical Examiner** Thapelo Andre Kwofie 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Min. Months Davs Hours Director 1 X M 2 Country) 220-77-3819 Yrs March 30 Maryland 02 200 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho or items 23a or 28a-f sho must be notified at once, Maryland | Montgomery Damascus Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Valley Park Court 20872 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Widowed If Yes, Give Year Yes 2 X No specify: the Medical Examiner Divorced Specify: Black ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ or other traumatic event, Andrew Yaw-Asare Kwofie Evelyn (NMN) Letsoalo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩ E Evelyn Kwofie, mother 13 Valley Park Court, Damascus, Maryland 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Pine 11/7/2009 Grove Cemetery Mount Airy, Maryland Denation 5 Other Specify: 22. Name and Address of FacilityMolesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 Part Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death a. Hanging cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? this certificate has been signed by the attendial director, page 2 should be detached for use Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? 1 V Yes 2 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes No funeral After 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 28c. Injury at Work Certification Subject hanged by curtaincord FOUND: 1 Natural 1 Yes 2 V No 24 hours after death. To the Funeral Director: completely filled in by the Pending Nov 1, 2009 1507 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 13 Valley Park Court, Damascus, MD determined (Specify) At home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) November 2, 2009 O.C.M.E nin 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Morth Cav 32. Redistrar's Signature State Registrar RUSTAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death NECKHEALTH MO REHAB yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Hours Yrs Director VIRGINIA 10-4-ZL Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be a sufficience once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☑ No ARD 10f. Zip Code 10g. Citizen of What Country? 28 H 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 Neyer Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 2 No Completed by 1 🗆 Yes Specify: 3 ₩idowed 4 Divorced Specify: WhITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ပ **UNK** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1860 CEDAR RD. PASADENIA, MO. DAUGHTER **Z1122** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-09 ODENTON Name and Address of Facility DAUGHERTY 21. Signature of uporal 2601 MOUNTAIN RD. PASADENA MO or complic nt 1. Enter the disease, or conshock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ecclin C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immunicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ゑ 2 🗌 No 3 Probably 4 □ Onknown Be Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🗆 N 2/No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. I Director: A
ad in by the f 1 □ Yes 2 Accident 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Rida

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11/4/2009 BEATRICE LEE LIGHTFOOT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 5220 LEVERETT STREET OXON HILL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🛣 F Washington,DC Director 215-42-8748 65 3/2/1944 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1X Yes 2 ☐ No Director Maryland | Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 United States 5220 Leverett Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No If Yes, Give Year or Dates: Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9 Private Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Booker Toland Iola Hutchinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Lightfoot / Son 5520 Leverett Street Oxon Hill, Maryland 20745 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important; If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2009 Riverdale, Maryland Riverdale Park 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosci **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☐ fes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier Medical 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

UR 5

State Registrar

NOV 1 0 2009

92. Registrer's Signature

Drive, Cheverly

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

\$

Be Completed

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21. Signatur

29b. Signature and title of certifier

ANDROW GORDON MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination and once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	resulting in death)	a. THEROSCEROLIC CARDIOVASCULAR DISE	758	_
	/ double of the county	Due to (or as a consequence of):		
		BRONCHIECTASIS		
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		_
를	cause. Enter Underlying Cause (Disease or injury that initiated events	CHRONIC GESTRUCTIVE PLLMONARY DISEASE		
Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):		_
ca		d CHROHN'S DISEASE		
Physician/Medical				_
<u>></u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	23d. Date of delivery	
ä	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year	
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ete		24a. W	Odb More extensy findings available	-
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Be (25. Was case referred to medical	26. Place of Death (Check on		_
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Certification:		Only of	iom, state	
ਕ ਕ	29a. Certifier 1 Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to	the cause(s) and manner as stated.	_
<u>త</u>	(Check only 2 Medical Exam	niner: On the basis of examination and/or investigation, in my opinion, death occurred at the tin	ne, date and place, and due to the cause(s)	

29c. License number

2003 Medical Phuy St 100 ANNAAUUS, MD

State Registrar

				Please							Are Legible	
			For State Registrar		State of I	Maryland		artment of F r <i>tificate of</i> .		Mental Hy	giene 20(Reg. No.	09 37483
			1. Decedent's Name	(First, Middle, La	ast)					2. Date of De	ath	3. Time of Death
	Physicia		Theda	a Marie 1	Pote Moyl	an				Month OCt.	29, 200	on 5:20 P M
	/Medic Examin		4a. Facility Name (If		_			4b. City, Town, o	r Location of Deat	h	4c. County of D	
1			Genesis	Elderca	re			Severna	a Park		Anne A	cundel
	Funeral		5. Social Security Nu		Sex 7. 1 □ M 2 💢 F	Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 9.	Birthplace (State or Foreign Country)
	Director		216-24-71	129	IL M ZLAF	80	Yrs.			Dec. 1	7, 1928 Pe	ennsylvania
	and and		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryi f sho	호	MD	Anne Art	undel	Se	verna	Park				1 □Yes 2 No
	the 1	irec	10e. Street and Num	nber		1		10f. Zip Code			10g. Citizen of What	: Country?
	3a or	Funeral Director	416 Sair	nt Ives I	Drive			2114	6		USA	
	death	ner	11. Marital Status		12. Was Decede Armed Force		13.1	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No	14. Race - A	American Indian,
0	after or ite	Fu		ed 2 Married	1 [Yes 2]		1	il ⊡Yes 2 X No	Specify:	to riloan, etc.)	Specify:	/hite, etc. White
2-002e	flied within 72 hours after death with the Maryland Hygiene. Hygiene. the Hydiene. there than "natural", or items 23a or 28a-f show ent, the Modical Examinat must be notified at	d by	3 Widowed		Ye ar or Date							
ה ה	"nati	lete	(Spec	15. Decedent's E sify only highest gr	Education rade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo	rking	16b. Kind of Busine	ess/Industry
7	withir ene. than	Completed	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)		ecretary	4/		Law Fir	rm.
2	filed Hygi other ent, I	l ou l	17. Father's Name (First, Middle, Las	it)				18. Mother's Na	ne (First, Middle	, Maiden Surname)	
2	ld be lental ked o	To B	Emory I	Pote, Sr	•				Helen	Romaine		
<u> </u>	shou and N s mar	-	19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	er, City or Town, Sta	te, Zip Code)
, Ma	and 2		Judith I	?. Moylar	n-Forman/	Daughte	r 41	6 Saint	Ives Dri	ve Sever	na Park, N	MD 21146
υ 5	of He		20a. Method of Disp		Removal from Sta	20b. Plac	ce of Disponence	sition (Name of matory or other plan CLEMATOL	WOV	Date 03,	20c. Location - City	
	. Pag tment tant: jury o		4 ☐ Donation	5 ☐ Other (Spec	ify)	ACIE		لبل	C	2009	Glen Bur	•
Daltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any Injury or other traumatic event, Its Modical Examinat must be notified at once.		21. Signature of Fu	Peral Service Lice	ensee		Į Ž	Name and Addre	Sons,	P.A. Sev	erna Park	Funeral Home
			23a, Part I, Enter th	ne disease, or cor	nplications that cau	sed the death.						MD 21146 Approximate
	Thursinian		shock, or hear Immediate Cause (rt failure. List only	y one cause on each	n line.	00		,		. ,	Interval Between Onset and Death
and a	Physician /Medical		disease or condition resulting in death)		a. Due to (or	as a conseque	C) / [,	19				aays
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	p #	iner	Sequentially list cor if any, leading to im- cause. Enter Under	nditions, mediate	Due to (or	as a conseque	nce of):					
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Ö,	be ex ician a	_	resulting in death) E		Due to (or	as a conseque	nce ot):					
00/00	ficate phys s the	Physician/Medica	d									
XOO O	certif	J/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outco						23d. Date of	f delivery
0	death e atte	iciaı	in the past 12	months?	4 🗌 Pregnai	h 2□Fetald ntat time of dea		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	СУ		Month	Day Year
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'n	ss tha gned se det		Part II. Other signif	icant conditions	contributing to deat	h but not resulti	ing in the u	nderlying cause giv	en in Part I.			te to the cause of death?
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ב	law r las b 2 sh	nple	insut	ticio	nai	Cong	05/	we 1	gart	24a. Was	psy prior	e autopsy findings available r to completion of cause of
=	: The	Co	toul	uve	Jai	ren	19			perfe 1 □ Yes	ormed? deat	th? Yes 2 □ No
VII.d	iclan certifi ector	Be	25. Was case referrexaminer?		Hospital:		, (Oth	26. Place of De	ath (Check only	one)	
5	Phys rthis	:To	1 ☐ Yes 2 ☐ 27. Manner of Death		1 ☐ Inp	atient 2 El	R/Outpatie	nt 3 🗆 DOA	4 Nursing		idence 6 Other (Specify)
200	ding th. Afte	tion	1 ☐ Matural 2 ☐ Accident	5 Pending investigation	(Month,	Day, Year)	Injury	Wor	kí? lYes 2 □ No	200. 200.720		
2	Atter r dea ector by the	ifica	3 ☐ Suicide	6 Could not		injury - At hom	e, farm, str	reet, factory, office		28f. Location	Street and Number of	or Rural Route Number,
5	s afte	Certification:	4 Homicide		building	etc. (Specify)				City or 10	wn, State)	
	lospil 4 hour uner: ely fill		29a. Certifier (Check only	Certifying P	Physician: To the beaminer: On the bas	est of my knowl	edge, deat	h occurred at the to	ime, date and place	e, and due to the	e cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one) 29b Sigrature and		and manne	stated.		29c. Licens			29d. Date signed (M	
	5. ₹ 5 8		290. Signature and	A .	1	1	•			725		3 -
•	DH	/	30. Name and addre	ess of person who	o completed cause	of death (hem	(Sa) [[vpe	Print)	4) 000	-	10-30 Lersville	
	4	V	()ennil	TerRio	dires	V 861	1 Va	torons	Highu	ou Mil	lersville	MD 2/108
	Sta		31. Date filed (Mont		2000 32 Beg	istrar's Signatu	e	1		1		11100
	Registr	ar		NOV 04	2009 Jan	sur p	9. 4	acked				

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		٠.	1 - State of Maryland / Dep	artment of Health and M rtificate of Death		ene g. No. 2009	37484
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month Nov 3,	Day Year	3. Time of Death
may	/Medic	al	John Walter Mashek 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	9:05 p ^M
	Examin	er	Montgomery General Hospital	Olney		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Year) 9. Birthp	place (State or Foreign
п	Director		504-24-9922 1™ 2□F 77 Yrs.	Months Days Hours Min.	Dec 9,1	931 Sout	h Dakota
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1	Od. Inside City Limits
	Maryl f sho	to	DC Washingt	on			1⊠Yes 2□No
	h the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
	th with	ral D	1415 31st Street NW	20007	τ	Inited State	es
36	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanimer must be notified at once.	by Funeral	1 □ Never Married 2 ■ Married 1 ■ Yes 2 □ No1953 −	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	etc.
0	hours Itural'	ed b	3 Widowed 4 Divorced Year or Dates: 1955 15. Decedent's Education 16a. Dece	edent's Usual Occupation	11	 6b. Kind of Business/In	dustry
215	nin 72 9. In "na	Completed	(Specify only highest grade completed) 1 (Give	kind of work done during most of work DO NOT use retired)	king		•
2	ed with	Con		nalist		Journalis	m
nd	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M	faiden Surname)	
3	12 should be fi h and Mental I 7 Is marked ot traumatic evel	ဥ	Walter Herbert Mashek 19a. Informant's Name/Relationship (Type. Print) 19b. Mail	Irene Ly		City or Town State 7ii	n Code)
Ma	and 2 s ealth an n 27 is i			31st Street NW Wa			2 2040)
altimore, Maryland 21215-0036	ss 1 al of Hea item		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Interpretation of Interpretatio	Date 2	20c. Location - City or To	own, State
Ē	Pages ment of I ant; If its ury or o		4 Donation 5 Other (Specify) Atlantic	Crematory 11/0		len Burnie,	
Balt	permit, Departr Importa any inju			2. Name and Address of Facility $ { m Jos} $ $$ $$ $$ $$ $$ $$ $$ $$ $$	•		
н			23a. Part 1. Enter the disease of complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death) Coronary Artery D	isease			
1	/Medical Examiner		Due to (or as a consequence of): Hypertension				
		er	Sequentially list conditions, If any leading 1, immediate Due to [or as a consequence of]:				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events Hyperlipidemia				
Ó,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				and the same
8760,	cate b physic the bu	dical	d			1	
O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of deliv Month	very Day Year		
σ.	res that the signed by be detact		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to 1	the cause of death?
rds	quires n sign ald be	d by	Cerebrovascular Disease		1 □ Ye	s 21 No 3 Pro	bably 4 🗌 Unknown
000	aw requir is been si 2 should I	Completed			24a. Was ar	24b. Were auto	opsy findings available
ž	The ate h	mo			autops perforn 1 🗆 Yes 2	ned? death?	ompletion of cause of 2 □ No
/ita	clan: ertific ector,	Be C	25. Was case referred to medical examiner?		th Check only one		
of	ding Physician: The h. After this certificate h. funeral director, page		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient ZX ER/Outpatie			nce 6 Other (Speci	ify)
on	ding I h. After funer	tion	27. Manner of Death 1	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe no	w injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (St. City or Town	reet and Number or Rur , State)	al Route Number,
	spital ours a leral C		29a. Certifier 1☑ Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the c	ause(s) and manner as	stated.
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	Vithi To th Comp	M	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,	, Day, Year)
	X-15		Malon Croater and	D17577		1/04/2009	
	F \		30. Name and address of person who completed cause of death (Item 23a) (Type		100 00	NO.1 F	
	Sta	te	Morton Kavalier MD 5454 Wisconsin Av 31. Date filed (Month, Day, Year) Registrar's Signature	e. #925 Chevy Chas	se, MD 20	21815	
	Registr		NOV 06 2009 Server D. Registrar's Signatura	M			

09-08735 Kathrvn M McRae

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		State of Maryland / 1- For State Registrar	Certificate of	_	Reg. No	2000	271.0
Physicia edical Exami		Decedent's Name (First, Middle,Last) A MILLENTY	DAT		2. Date of Death Month Day November 10,	2009 Year	rime of Seath 1 1 0 0830 hrs
		4a. Facility Name (if not institution, give street and number)	erae 4	b. City, Town, or Location of Death	4	c. County of Death	
		18307 Hallmark Court		Gaithersburg		Montgomery	(0)
Funeral Director		216-19-6087 1 M 2 XF	e (În yrs. last birthday) 34 Yrs.	Months Days Hours Min.	JUNE 3,	VDD/YYYY) 9. Birthpl Counti 1975 MAR	
w any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on			d. Inside City Limits
faryland 28a-f show Latonce.	tor	MD . MONTGOMERY 10e. Street and Number	GA	ITHERSBURG	I 10g Cit	tizen of What Country	XYes 2 No
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	18307 HALLMARK CT.		20877	109. 01	U.S.A.	•
with t ms 23a be not		11. Marital Status 12. Was Decedent		Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American White, etc.	Indian, Black,
or ite	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2	X No		rican, etc.)		ır
5-0036 led within 72 hours after tygiene. other than "natural",	t by	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com		Yes $2 \overline{X} $ No specify: 's Usual Occupation (Give kind of v	vork done 16b.	Specify: WHIT Kind of Business/Indu	
5 72 hou in "nai cal Exs	Completed	Elementary/Secondary (0-12) College (1-4 or 8	during mo	st of working life. DO NOT use reti	red)		
15-003 illed within Hygiene. d other the	omp	12	H	EALTH AID	(First, Middle, Maider	HMO	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) ROBERT A. FOS	STER	16.Mother's Name	JENNIE	GAYLOR	
Baltimore, MD 21215 pernit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumatic event, II.	TO E	19a. Informant's Name/Relationship (Type, Print.)		Address (Street and Number or F			p Code)
MD and 2 sho salth and em 27 is raumati		MILDRED EVELYN SEAL/ MOT 20a. Method of Disposition	<u> THER 15107</u>	INTERLACHEN DR.		SPRING, MI Location - City or To	
ges 1 a tt of He t: If it		1 Burial 2 X Cremation 3 Removal from Sta	ate crematory or oth	er place)		·	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Sept/ce Licensee		CREMATORY 11- emp and Address of Facility AMBERS FUNERAL H	-18-2009	RIVERDALE	
Dep Der	1	M. M. Chamberson	M00091 58	O1 CLEVELAND AVI	E., RIVERD	ALE, MD. 2	.A. .0737
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter th	e mode of dying, such as cardiac o	r respiratory arrest, sh	nock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Pneumon: Due to (or as a conse					Death
		Sequentially list conditions, b.					
	ine	if any, leading to immediate cause. Enter Underlying Cause C. Due to (or as a conse	equence of):				
be isi	Examine	events resulting in death) Last Due to (or as a conse	equence of):				
executed an and al - transit		MUNPENDED d.	00 07 7	000 1/0/10 m			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	IF FEMALE: 23c. If yes, outcor	23a,2/,permE	, g899 1/8/10 T		3d. Date of delivery	
Box 687 death certific the attending p	ian/	23b. Was decedent pregnant in the past 12 months?	time of death	al death 3 Ectopic pregna	ancy	Month Day	Year
Box death the atte	Physician/	1 Yes 2 No 9 V Unknown g Unknown	5 Ott	ner (Specify)			
P.O. Ess that the d	by P	Part II. Other significant conditions contributing to death	h but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	o use contribute to the	e cause of death?
ords, F w requires as been sign should be	fed				24a. Was an		osy findings available
COrc law re has be e 2 sho	Completed				autopsy performed?	prior to con death?	npletion of cause of
tal Rec cian: The certificate ector, page		25. Was case referred to medical		26.Place of Death (Check	only one)	No 1 Yes	2 No
of Vital Records, of Physician: The law require the continue has been si meral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No	ent 2 ER/Outpatient	[Other:		dence 6 🗸 Other: S	cene
ion of tending Ph eath. tor: After t	on: T	27. Manner of Death 1 Natural 5 Panding 28a. Date of Inju (Month, Day,Y	ry 28b. Time of Ir		28d. Describe how in	njury occurred	
Division tal or Attendii rs after death. ral Director: A led in by the fu	Certification:	2 Accident Investigation	iury - At home farm stree	1 Yes 2 No	28f Location (Street	and Number or Rural	Route Number City
Divis pital or At ours after d reral Direc filled in by	ertif	3 Suicide 6 Could not be determined (Specify)	gary 7 kmomo, rami, osoo	i, restery, emos banding, etc.	or Town, State)	and named of name	ricato rempor, ony
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of m					
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigati				
	2	29b. Signature and title of certifier	r)	29c. License number O.C.M.E.		i. Date signed <i>(Month</i> ovember 11, 200	
		Japuel Buthelli 194					
		30. Name and a dress of person who completed cause of d	leath (Item 23a)				
		Pamela E. Southall, MD Assistant Medi	,	1 Penn Street, Baltimore, N	MD 21201		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:40 AM Olga Nancy Murphy November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Itavre de Grace Zens 8. Date of Birth (Month, Day, Year, Dec. 27, 1 Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New York Security Number **Funeral** Days 1 □ M 2 💢 F 95 050-01-8789 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Cecil Director Maryland Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 24 Misty Meadows Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) marked other than Personal Residence Eight Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental F 7 Is marked ott Be Eduardo Palumba Annette Vanucci ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any injury or other tra 1223 Dr. Jack Road, Conowingo, Maryland Joyce Eder (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place Cemetery of the 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/09 Brooklyn, New York Holy Cross Holy Cross Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due (or as a consec **Physician** aselle /Medical (or as a consequence of) Examiner Sequentially list conditions, Date to for each a nonsectioned offi-Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed bunial-trar and Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 3 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/4/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 0 2009 Registrar

Murphy, Olga

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0639 A TOV Joan L. McGovern /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SAINT HGNES HOSPITA IMORE 5. Social Security Number 8. Date of Birth Month Day, Year) 12/30/1933 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Hours 220-30-6398 Director MD Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show 28a-f show 10d. Inside City Limits 1 □Yes 2 No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itеms 23a 5818 Montgomery Rd. 21075 United States by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ,0, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Specify: "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygier them 27 is marked other them other them. 12 Travel Agent Travel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Trogler Thelma Weidman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael S. McGovern - son 5878 Montgomery Rd Elkridge, MD 21075 other 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State Ardent Crematory 4 Donation 5 Other (Specify) 11/10/09 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Die M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, SEPTIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine TRACT INFECTION Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 1 □Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home Medical Certification: To 1 hpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending e Hospital or Attendi 24 hours after death. e Funeral Director: A letely filled in by the fi 2 Accident investigation 1 ☐Yes 2 ☐No 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 3 ON AVE, BALTIMORE State Registrar

NCGOVERN

09-08614

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Cira Javan Mendez	Stat	e of Maryland / D	epartment of Certificate of	Health and	Mental Hy		200	9 3748
Physician/	Registrar 1. Decedent's Name (First, Middle,L		Certificate of	Death		2. Date of Death	1	3. Time of Death
Medical Examiner	Cira Javan Men	ndez			The of Dooth	Month November	5, 2009 Year 4c. County of Deat	2157 hrs
	4a. Facility Name (if not institution, gas Shady Grove Adventist		ľ	b. City, Town, or I Rockville	Location of Death		Montgomery	"
Funeral	Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year		8. Date of Birtl	h(MM/DD/YYYY) 9. Bi	rthplace (State or gn Washington
Director	578 47 0462 1	M 2XF 2	Yrs	Months Days	Hours Will.	04/10	/2007 c	ountry) D.C.
au À	Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Locati	on		<u> </u>		10d. Inside City Limits
nd show a	MD Montg	omery	Rockville					1 X Yes 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	5709 Ridgeway A	12. Was Decedent Eve	arin IIS 13 Wa	20851	panic Origin? (Sp		USA 14. Race - Ame	rican Indian, Black,
er death with t v, or items 23a	1 X Never Married 2 Marri	ied Armed Forces?		es, specify Cuban,	, Mexican, Puerto	Rican, etc.)	White, etc.	
s after d		ced If Yes, Give Year	1X		specify: Ecua			nite
"natur Exam	15. Decedent's Education (Specify Elementary/Secondary (0-12)	y only highest grade completed College (1-4 or 5+)	ted) 16a. Deceden during m	t's Usual Occupati ost of working life.	ion (Give kind of w DO NOT use retir	red)	16b. Kind of Business	rindustry
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exat	N/A	Conoge (1 1 c. c)	Non	e			None	
15-0(liled wi Hygie d other	17. Father's Name (First, Middle, La	ast)			18.Mother's Name Marika	•	Maiden Surname)	
2121: ould be fi d Mental I s marked tic event,	Luis Mendez 19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Stree			nber, City or Town, Sta	te, Zip Code)
MD 12 shorth and 127 is umatic	Luis Mendez (fa	ther)					MD 20851	
ore, S I and of Heal If item	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from State	20b. Place of Dispos crematory or ot	ner place)	i i	Date	20c. Location - City	
time t. Page tment or trant: ' or oth	4 Donation 5 Other Spec	cify:		tan Crem		09/2009	Alexandri	a VA
Bal permii Depar Impoi		~ /	L A d	vent Fun	eral & C	remation	n Sves	
Physician	23a. Part I. Enter the disease, or confailure. List only one cause or	n ëach line						Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease	a Myocarditis		luenza (1	H1N1) in	fection		Death
ì l	or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence)	ence of):					
iner	if any, leading to immediate cause. Enter underlying cause	Due to (or as a consequent	ence of);					
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ence of):					
e execution and ital - tra	X UNPENDED	AMENDED 33 - 3	27.per ME	g800 1/8	10 TT			
3ox 68760, leath certificate be e attending physici Ifor use as the burings of ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy				23d. Date of deliver	ery Day Year
OX 68 sath certif attending for use as	past 12 months?	1 Live birth 4 Pregnant at tim	n of dooth	etal death 3 ther (Specify)	Ectopic pregna	ancy	World	Day Tour
—	1 Yes 2 No 9 Unknown	9 GIRIOWII	it not reculting in the	underlying cause	niven in Part I	23e. Did to	obacco use contribute	to the cause of death?
P.O. s that the strate of e detac		ns contributing to death bu	at not resulting in the	underlying cause (given in i dit i.			robably 4 Unknown
rds, require been si hould b	-					24a. Was		autopsy findings available o completion of cause of
(ecords, he law requires are has been signage 2 should be ompleted			<u> </u>				rmed? death	
of Vival Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on: To Be Completed by P	25. Was case referred to medical examiner?	Hespital			Other			
of Viv	1 V Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		Iry at Work?	ng Home 5	Residence 6 Ot how injury occurred	ner:
Sion of Attending Ph r death. ector: After t by the funeral cation: T	1 X Natural 5 Pendir	(Month, Day,Year			Yes 2 No			
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	2 Accident Investi 3 Suicide 6 Could determ	not be 28e. Place of Injury	y - At home, farm, stre	et, factory, office t	building, etc.	28f. Location (or Town, 5		Rural Route Number, City
Divi Hospital or 24 hours afte Funeral Dir tely filled in	00- 0-46	rsician: To the best of my ki	nowledge, death occu	rred at the time, d	ate and place, and	d due to the cau	se(s) and manner as s	tated.
To the Ho within 24 f To the Fu completely	one) Medical Exam	iner:On the basis of examin and manner stated.	nation and/or investiga	ation, in my opinior		at the time, date	and place, and due to	
× × ×	29b. Signature and title of certifier	0. 11			M.E.		November 6, 2	
	30. Name and address of person w	vho completed cause of dear	th (Item 23a)				<u> </u>	
	Laron Locke MD. As	sistant Medical Exam	niner 111 Pen	n Street, Balti	more, MD 212	201		
State Registra	31. Date filed (Month, Day, Year)	Registrar's	Signature	2.0				
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			1- State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	partment of Health and Nertificate of Death		ene 2009	37490
	Physici		1. Decedent's Name (First, Middle, Last) Margaret C. Newman		2. Date of Death Month November		3. Time of Death 3:30 a M
j.	/Medi Examir		4a. Facility Name (If not institution, give street and number) Charles County Nursing & Rehab	4b. City, Town, or Location of Death LaPlata		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1		8. Date of Birth (Month, Day,) Aug. 8,	(ear) 9. Birth	nplace (State or Foreign untry) ryland
	D.		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or to	ocation	rag. o,	1910 Fid.	10d. Inside City Limits
	the Mar 28a-f	Director	Maryland Charles White	Plains 10f. Zip Code	100	g. Citizen of What Co	1 ☐ Yes 2 MNo
	th with 23a or	al Di	4225 Southwinds Place, Apt. 216	20695		U.S.A.	and y :
920	should be filed within 72 hours after death with the Maryland Menial Hyglene. Transked other then "neturel", or Iteme 23a or 28e-f show marked other then "neturel", or Iteme 24 or 28e-f show mails event, the Madical Examiner must be neithed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wwidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No It Yes, Give A Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ Yo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	within 72 ho ane. then "netur	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ng	6b. Kind of Business/I	ndustry
ک 2	I Hygi other	0	17. Father's Name (First, Middle, Last)	ounting Clerk 18. Mother's Name		J.S. Govern	nment
ylar	should be f and Mental I marked of	To B	Richard Hugh Knott		1. Smith		
Mar	nd 2 sh lith and 27 is m r treum		100	ing Address (Street and Number or Rura O Dogwood Dr., Whi			
Baltimore,	permit. Pages 1 end 2 should by Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic en 2002.		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposerery, cre-	osition (Name of omatory or other place) Nov. 13, cles Cemetery	2009 20	oc. Location - City or T	
Balt	permit. Departr Importe eny inje		21. Signature of Funeral Service Lice M00668	Name and Address of Facility Villiams Funeral Ho 1270 Hawthorne Rd.,	me, P.A.		20640
			23a. Part1. Enter "e isease, or complications that baused the death. Do not er shock, or he in tillure. List only one cause or each line.	iter the mode of dying, such as cardiac of	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cau (a D inal disease or condition resulting in death) a. Due to (or as a consequence of):	IC-ADENO-	CARCI	NOMA	Short and South
	Examiner		Sequentially list conditions, b.				
	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury				
8760,	cate be executed bhysicien and the burial-transit	dicai Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
	artificating phy e as the	Medic	IF FEMALE:				
O. Box	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	very Day Year
Vital Records, P	w requires that the de been signed by the should be detached	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. EART DISEAS		cco use contribute to	the cause of death?
eco	lawre	Completed	HYPERTENSION		24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
		e Cor	HYPOTHYROIDISM 25. Was case re erred to medical		performe 1 ☐ Yes 2 2	d? death? No 1 ☐ Yes	2□ No
O V	Physician: rthis certifici ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		ce 6 □Other (Spec	ify)
DIVISION O	ath. or: Affer the funera		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Injury 28a. Date of Injury (Month, Day Year) Injury		8d. Describe how		
Š	s efter de el Directo ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours elter death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a livestigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier And And And And And And And And And And	29c. License number		I. Date signed (Month	
ſ,	4211		30. Name and address of person who completed cause of death (Item 23a) (Type VIDYA SAGAR ANMANGANDLA	D002601 4D / 10583-T WHITE	HEODO	RE GRE	EEN BLVD
	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 0 9 2009 32. Degistrar's Signature	WHITE	PLAII	VS, MD-	20695

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 2009 **Physician** LAWRENCE RONNIE NEWMAN November /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LAPLATA HARL IVISTA MEDICAL ENTER Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
MARCH 18,1943

9. Birthplace (Sta 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F Months Days 212-38-3934 Director 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hydiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Exemples 11 Yes 2 No Funeral Director MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 109 BERTHA CIRCLE 20640 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2
No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No þ If Yes, Give Year or Dates: Specify: BLACK Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10TH GRADE College (1-4or 5+) NUCLEAR POWER PLANT **OPERATOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked RICHARD LEONARD NEWMAN BERTHA ANN QUEEN NEWMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY NEWMAN / WIFE 109 BERTHA CIRCLE, INDIAN HEAD, MARYLAND Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART CEMETERY NOV. 10, 2009 LA PLATA, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of ying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause of Carlute Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner LEUMONEO Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting it 23e. Did tobacco use contribute to the cause of death? the underlying cause given in Part I. à sign 1 ☐ Yes 2 ☑ o 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed Were autopsy findings available prior to completion of cause of death? autopsy perform 2 12 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 24 hours after deat Funeral Director: 6 Coald not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) etermined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely Within 2 and manner stated. 29b. Signature and title of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. CHOL 32. Registrar's Signature 31. Date filed (Month Year) State

DHMH 17 Rev 1/2001

Registrar

ENCI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 04 Gary W. Outten /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIONAL HICOMICO TENINSULA If Under 1 Year | If Under 24 H/s 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth (Month. Day, Year) Social Security Number **Funeral** Days **¼**□ M 2□ F 58 219-56-9003 MD 4/16/1951 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State rat", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 6116 Jack Drive 14. Race - American Indian, Black, White, etc. White 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or itel 1 □ Yes 2 □ No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Still ဥ Granville Outten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6116 Jack drive, Salisbury, MD 21804 Lucinda Outten/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Snow Hill, MD 11/9/2009 Makemie Churchyard 5 Qther (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 208 W. Federal St., Snow Hill, MD 21863 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure? List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (as anoma **Physician** Hepatocellular /Medical Due to (or as a consequence of) **Examiner** patorena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Gastric burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

9.16

106 Milford ST # 405B

, salisbusy,

MD 21804

M.D

Das.

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 10:15 P M ROBERT SEAMAN OAKLEY Nov. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Center Bel Air Upper Cheaapeake Medical 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) (1ay 22, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) New Days Hours 1 X M 2 □ F York May 098-14-1903 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once. 1 ☐ Yes 2 No Director Harford MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States #2-A 21014 802 Candlelight Drive Funeral 12. Was Decedent Ever WWS. II as Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?

1 Xi Yes 2 □ No If Yes, Give Year or Dates: Korea

1 □ Yes 2 XiNo Specify: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 ☐ Divorced Korea 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household Products Warehouseman 111/2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Henrietta Oltman Oakley Florence George Dewey မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21014 19a. Informant's Name/Relationship (Type. Print) Candlelight Dr. #2-A Bel Air, MD. Carol S. Oakley (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/09 Owings Mill, MD. 4 □ Donation 5 □ Other (Specify) Garrison Forest 22. Name and Address of Facility 21. Signature of Funeral Service License E.G. Kurtz & Son Funeral Jarrettsville, Maryland Alacklen Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** dona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of pertifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 520 upper Che Sapoake Dr., Suite 308 Bel Air, MD 21014 att Ishak 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 09-08506 Karen M. Prince

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2009 37494

		- For State Registrar	Certifi	cate of Dea	ath		Reg	. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year	3. Time of Death
ledical Exami	ner	Karen M. Prin					Month I November 2		1437 hrs
		4a. Facility Name (if not institution, give str				ocation of Death		4c. County of Dea	
		Prince George's Hospital Cer			everly	If Under 24Hrs	O Date of Birth		irthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Moi	nder 1 Year nths Days	Hours Min	. 1	C	country)
Director			2 XF	56 Yrs.			May 11	,1953	VA
any	H	Usual Residence of Decedent 10a. State 10b. County	10c. City. Tov	vn or Location			· · · · · ·		10d. Inside City Limits
* .	.	-							1 X Yes 2 No
Aaryland 28a-f show Latonce.	용	MD PG 10e. Street and Number		Fort Wa	<u>asnin</u> Zip Code	gton	100	g. Citizen of What Co	untry?
or 28	Director	2508 Corning Av	o #2		2074	Λ		nited St	-2+05
with the s 23a s 23a			2. Was Decedent Ever in U.S.	13. Was Dece			pecify Yes or No-		erican Indian, Black,
eath v item	Funeral	1 X Never Married 2 Married	Armed Forces? Yes 2 X No			Mexican, Puerto		White, etc.	
fter d I", or ier m		3 Widowed 4 Divorced If Y		1 Yes	2 X No	specify:		Specify:Bla	ack
ours a atura camir	d by	15. Decedent's Education (Specify only h	nighest grade completed) 16	a. Decedent's Usu		on (Give kind of OO NOT use ret		16b. Kind of Busines	
5 72 h ru "n cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				· .		
5-0036 iled within 72 Hygiene. I other than "	Ē		4	Securit				Alpha Se	ecurity
filed Thyging Hyging doth		17. Father's Name (First, Middle, Last)			18		e (First, Middle, Mi		
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ic event, the Medical	Be	George Parker 19a. Informant's Name/Relationship (Type	Print \	19h Mailing Addr	ess (Street		e Reyn	OLGS ber, City or Town, Sta	ate Zin Code)
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho tumatic event, the Medical Examiner must be notified at once	은	Syreeta Prince/o		5203 Da Suitlar			race	, on , on , on , on	,р осто,
nore, MD 21215-003 ges 1 and 2 should be filed within nt of Health and Mental Hygiene. t: If item 27 is marked other to		20a. Method of Disposition	20b. Plac	e of Disposition (N	lame of cem	etery,	Date	20c. Location - City	or Town, State
			Kemovai nom State	natory or other pla Ony Men	,	11 Park	/7/09	Landove	er.Md.
Baltimor permit. Pages Department of Important: If injury or othe		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		_			daes &	Edwards	
Balti permit. Departr Import injury		Janice Ed	Marda						1,Md.20746
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each		not enter the mod	de of dying, s	uch as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Medical xaminer			ıltiple Injuries						Death
Adminer			e to (or as a consequence of):						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due	e to (or as a consequence of);		_				
	ij	cause. Enter Underlying Cause (Disease or injury that initiated	to to the as a consequence on.					_	
si id	Examiner	events resulting in death) Last	e to (or as a consequence of):			-			
760, cate be executed physician and the burial - trans		d	MENDED						
760, cate be ex physician he burial	Medical		MENDED					20d Date of delic	
		23b. Was decedent pregnant in the	23c. If yes, outcome of pregnan 1 Live birth	2 Fetal dea	ath 3	Ectopic pregn	ancy	23d. Date of deliv Month	Day Year
ox 68 eath certiff	sician		4 Pregnant at time of death	_					
Box te death c the atten ted for us	Phys		9 Unknown			5	Loop Did to		to the cause of death?
P.O.	by P	Part II. Other significant conditions co	intributing to death but not resul	Iting in the underly	/ing cause gi	ven in Part I.			robably 4 Unknown
S, P.C puires that an signed							24a. Was a		autopsy findings available
ords aw requi as been 2 should	plet						autops	y prior	to completion of cause of
Rec The la	Completed						1 Yes 2		
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certificate hours after death. Funeral Director: After this certificate has been signed by the attending lely filled in by the funeral director, page 2 should be detached for use as	Be (25. Was case referred to medical examiner?	pital:			of Death (Check			
Physic aldir	T ₀	1 ✓ Yes 2 No	i inpatient 2 V Li		DOX	y at Work?		Residence 6 Of Officer	her:
n of ding Ph	on:	27. Manner of Death 1 Natural 5 Pending	(Month Day Year)	334 hrs		es 2 V No		truck by auto	
Sior Attend r death ector: by the	cati	2 ✓ Accident Investigation	28e. Place of Injury - At home	farm street fac			28f Location (S	treet and Number of	Rural Route Number, City
Division piral or Attendio ours after death. teral Director: Affilled in by the fi	Certification:	Suicide 6 Could not be determined	(Specify) Parking Lot	5, 101111, 511 001, 100	ory, omeo be	andrig, oto.	or Town, St	ate)	ay, Gien Daie , MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier 1 Continue Physician	To the best of my knowledge,	death occurred at	the time, dat	te and place, an	1		
To the Hos within 24 h To the Fur completely	Medical	one 2 Medical Examiner: O	n the basis of examination and/	or investigation, ir	my opinion,	death occurred	at the time, date a	and place, and due to	the cause(s)
To with Con	Me	29h. Signature and title of certifier	nd manner stated.		29c. License	number	-	29d. Date signed (Month, Day, Year)
		/ Cal molo old	$\langle \mathcal{O} \rangle$		O.C.N	Л.E.		November 3, 2	2009
0 /	(30 Name and address of person who con	npleted cause of death (Item 23						
25			nt Medical Examiner	111 Penn Stre	eet, Baltim	nore, MD 21	201		
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.1					
Regis		NOV 0 9 2009 AL	was p. ga				 		
DHMH 17 Rev 1/2	001	UCIVIE		ADICINAL					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 37495 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 09 **Physician** EINERS 1611 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Hospice House Harwood If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 71 Yrs. 8. Date of Birth (Month, Day, Year) 7/24/1938 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 12 M 2□ F Days Hours Min NH 002-26-5984 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Gambrills Director MD Anne Arundel 1 ☐ Yes 2/7(No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 2008 Huntwood Dr. Funeral death death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No 1956− If Yes, Give Year or Dates: 1961 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White þ 1 ☐ Yes XXNo Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) IBM 4 Sr. Market Support uith and Mental Hygir 27 is marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Frederick James Reiners Veronica Rita Kenney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 2008 Huntwood Dr. Gambrills, MD 21054 Spouse Susanna Reiners 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of the Fields 11/7/2009 | Millersville, MD 4 ☐ Dorfation 5 ☐ Other (Specify) 21. Signature of Fun Val ervice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. P. 11. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ick, or help it ailure. List only one cause on each line. Approximate Interval Between Imm di⊦te Cause (Frial dise si or condition resul ing in dea n) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) HUSPILL 6 Other (Specify) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of it or Attending Patter death. 28c. Injury at Work? HOUSE 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number to completed cause of death (Item 23a) (Type Print)

State Registrar 31. Date filed (Month, Day, Year) NOV 0 4 2009

32. Pegistrar's Signature
Annu B. Janes

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ENTA M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 28, 2009 **Physician** 2:24 A Reynolds Melinda Ann /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chevar Prince Hospita ever 5 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-1-1949 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Kershaw, SC Min Days 1 □ M 2 🖾 F 577-66-1672 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural" or Items 23a or 28a-f show traumatic event, the Middle Event or must be nothed at Washington y⊡Yes 2 No DC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20019 4204 East Capitol St NE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify. \$ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Government Meter Reader 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willene Danzy Newman James ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum once. 4325 3rd St SE #304 Washington DC Kimberly Reynolds/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 11-7-2009 Alexandria Va 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Washington 21. Si natur of Fure Pope Funeral Home 2617 Penn Ave SE DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ne umones **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) s been signed by the sahould be detached to a I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No HI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 st autopsy performed 1 ☐ Yes 2 ☐ No 2 🗆 No 1 🗌 Yes After this certification funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

state NOV 1 0 200

se. Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 29 Physician/ 200^{Yea} 12:50 p^M Betty Covey Starr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kent Chestertown Nursing and Rehabilitation Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Maryland **Funeral** (Month, Day, Year) an 18, 1928 Days Hours Min Director 218-30-0945 81 Jan Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 Yes 2 To Maryland Chestertown Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö rral", or items 23a or Examiner must be Funeral USA 21620 100 Clipper Way 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White. etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Maryland 21215-0036 1 Yes 2 No White "natural", 3 Widowed 4 Xpivorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Small Business Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Effie Moore Jacob Lee Covey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5645 Church Hill Road Chestertown, MD 21620 Daughter Shelly Coleman Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation Cntr 11/2 Stevensville, MD 21. Signature of Funeral Service Licensee Chestertown, Maryland 22. Name and Address of Facility Fellows, Helfenbein, & NEwnam Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER nunth METASTATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Esque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the himself. Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 2 No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown ALZHEIMENS DEMONTIA 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0041587 MO 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLITES CHESTERTOWN, MD. 21620 ms State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0412 M **Physician** OSA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Clinton Georges Prince 8410 Joan Place If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Months 1 🗆 M 74 Cárolina 11/08/34 Director 243-46-8705 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the "Nexical Examination and the natified at 1 ☐ Yes 2 No Director Prince Georges Clinton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8410 Joan Place 20735 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technican DC Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Celestia Knight Henry J. Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8410 Joan Place Clinton MD 20735 Monica Brown/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Bunal 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 11/07/09 Suitland, MD tion 6 Other (Specify) 22. Name and Address of Facility 420 H Street NE 21 Signa BK Henry Funeral Chapel Wash DC 20002 1178 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each light Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760. þ Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 ☐ Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 3 Probably 4 Unknown 2 🗆 No icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 ☐Yes 2 No 1 □Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated To the within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number ame and address of person

Registrar

State

32. Regiarar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 **Physician** 2:08 P M NOVEMBER 2009 **SESAY** KANDEH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY ROCKVILLE CASEY HOUSE 8. Date of Birth (Month, Day, DEC • 15 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, Funeral Hours Min. Days 1 DM 2 □ F Months SIERRA LEONE 1945 63 215-72-7303 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ral", or items 23a or 28a-f shov Examiner must be notified at 1 AYes 2 No Director PRINCE GEORGE'S RIVERDALE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 20737 6211 SHERIDAN STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐Wo Specify: 2 3 Widowed 4 Divorced "natural" Completed er than "natur, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 5+TEACHER other 1 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BOMPOROH SESAY SESAY SIO ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 MANCHESTER RD #101 SILVER SPRING, MARYLAND 20901 Item 2 ARTHUR SESAY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 11/14/2009 Department of Important: If It any injury or oguce. 1 Burial 2 □ Cremation 3 □ Removal from State Adelphi Maryland Donation 5 Other (Specify) GEORGE WASHINGTON CEME J. B. JENKINS FUNERAL HOME neral Ser 22. Name and Address of Facility 21. Signature of Fa 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the deese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DISSECTING AORTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P 2 🗌 No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Koucel NOVEMBER 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year) NOV 1 0 2009

JOCELYN T. KOUATCHOU M.D. 201 EAST UNIVERSITY PARKWAY BALTIMORE, MARYLAND 21218 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 37500 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2009 Mildred Ann Savage 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Regional KICIMICO TENINSHUA 39/136UN4 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Mrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F 67 6-28-1942 Director 230-50-4161 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show traumatic event, the Medical Examinar must be notified at Salisbury 1 ☐ Yes 21 No MD Wicomico Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 21801 U.S.A. 875 Victoria Park Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Items 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 📉 No Specify. 2 Black 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Dr. Stephanides permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumaric Caregiver 1 Ω 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Mae Fiddemon William Ward, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Savage, Sr./Husband 875 Victoria Park Dr.Salisbury, MD 21801 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other bidge) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Cremation, 11/3/2009 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith 917 W. Isabella St Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Carcinoma of LUN **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examine be executed burial-trar attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 14 No 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check and manner stated. the within 7 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

2